**MASSHEALTH SENIOR CARE OPTIONS**

**FIRST AMENDED AND RESTATED CONTRACT**

**FOR SENIOR CARE ORGANIZATIONS**

**BY AND BETWEEN**

**THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**AND**

**[TBD]**

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This Contract is between the Commonwealth of Massachusetts, acting by and through the MassHealth Office of Long Term Services and Supports of the Executive Office of Health and Human Services (EOHHS), and [TBD] (the Contractor). The Contractor's principal place of business is: [TBD]

**WHEREAS**, EOHHS is an agency of the Commonwealth of Massachusetts responsible for operating a program of medical assistance (MassHealth) under 42 USC §1396 et seq., and M.G.L. c. 118E, §1 et seq., designed to pay for medical services for eligible individuals;

**WHEREAS**, the Contractor is in the business of providing medical services and EOHHS desired to purchase such services from the Contractor;

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

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

# DEFINITIONS OF TERMS

The following terms or their abbreviations, when capitalized in this Contract and its Appendices, are defined as follows, unless the context clearly indicates otherwise.

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

(1) the failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.6**.;

(2) the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;

(3) the reduction, suspension, or termination of a previously authorized service;

(4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:

(i) failure to follow prior authorization procedures;

(ii) failure to follow referral rules;

(iii) failure to file a timely claim;

(5) the failure to act within the timeframes in **Section 2.4.A.14** for making authorization decisions

(6) the denial of an Enrollee’s request to dispute a financial liability; and

(7) the failure to act within the timeframes in **Section 2.8.D** for reviewing an Internal Appeal and issuing a decision.

**Aging Services Access Point (ASAP)** - an entity organized under Massachusetts General Law (M.G.L.) c.19 §4B that contracts with the Executive Office of Elder Affairs to manage the Home Care Program in Massachusetts.

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

**Appeal** – An Enrollee’s request for formal review of an action of the Contractor in accordance with Section 2.8 of the Contract.

**Appeal Representative** - any individual that the Contractor can document has been authorized by the Enrollee in writing to act on the Enrollee’s behalf with respect to all aspects of a Grievance or Appeal (whether internal or external). The Contractor must allow an Enrollee to give a standing authorization to an Appeal Representative to act on his/her behalf for all aspects of Grievances and Internal Appeals. The Enrollee must execute such a standing authorization in writing according to the Contractor’s procedures. The Enrollee may revoke such a standing authorization at any time. When a minor is able, under law, to consent to a medical procedure, that minor can request an Appeal of the denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent or guardian.

**Capitation Rate** - a fixed monthly fee paid prospectively by EOHHS to the Contractor for each Enrollee for all Covered Services actually and properly delivered to the Enrollees in accordance with and subject to the provisions of this Contract and all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended.

**Centers for Medicare & Medicaid Services (CMS)** - the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

**Centralized Enrollee Record (CER)** - centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions. See **Section 2.4.A.8-10** of the Contract for more information about the contents of the Centralized Enrollee Record.

**Chronically Homeless** – individuals who meet the definition of “Chronically Homeless” as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years..

**Complex Care Need** - any condition or situation that demonstrates the Enrollee's need for expert coordination of multiple services (see **Section 2.4.A.4** of the Contract), including, but not limited to: clinical eligibility for institutional long term care; and medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

**Comprehensive Assessment** - A tool prescribed by EOHHS in **Appendix M** to be used by the Contractor to document the physical, cognitive, behavioral and emotional functioning of a MassHealth member, including activities of daily living and instrumental activities of daily living, formal and informal supports, and need for services.

**Consumer** – a MassHealth Member, aged 65 or older, or the spouse, sibling, child, or unpaid Primary Caregiver of a MassHealth Member who is aged 65 or older.

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

**Contract** - the participation agreement that EOHHS has with a Contractor, setting forth the terms and conditions pursuant to which an organization may participate in the MassHealth Senior Care Options Program.

**Contract Management Team** - a group of EOHHS and CMS representatives responsible for the management functions outlined in **Section 3.1** of the Contract.

**Contractor** - any entity located in the United States that is approved by EOHHS to be a Senior Care Organization and that enters into a Contract to meet the purposes specified in this Contract.

**Contract Year (CY)** - a twelve month period commencing January 1, and ending December 31, unless otherwise specified by EOHHS.

**Covered Services** - those services listed in **Appendix A** of the Contract delivered in accordance with **Sections 2.4 and 2.6** of the Contract. For the avoidance of doubt, Covered Services shall not include any items or services for which payment is prohibited pursuant to 42 U.S.C. § 1396b(i)(16) and 42 U.S.C. § 1396b(i)(17).

**Cultural and Linguistic Competence** – competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Service**s**

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

**Discharge Planning** - the evaluation of an Enrollee’s health care and social support needs, including long term care, mental health or substance abuse service needs, in order to arrange for appropriate care after discharge from an institutional level of care to another level of care.

**Dual Eligible Senior** – a senior, aged 65 or older, who is eligible and enrolled in Medicare Parts A and B and MassHealth Standard coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus) and Specified Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) aged 65 or older and with MassHealth Standard coverage.

**Eligible Individual** – a MassHealth Member enrolled in MassHealth Standard and satisfying the criteria set forth in 130 CMR 508.008(A).

**Eligibility Verification System (EVS)** - the online and telephonic system Providers must access to verify eligibility, managed care enrollment, and available third party liability information about Members.

**Emergency Condition (also known as Emergency Care)** - when an Enrollee, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. An Emergency Condition may not be limited on the basis of lists of diagnoses or symptoms.

**Encounter Data** – a dataset provided by the Contractor that records every service provided to an Enrollee. This dataset shall be developed in the format specified by EOHHS and shall be updated electronically according to protocols and timetables established by EOHHS in accordance with **Appendix I**.

**Enrollee** – a MassHealth Member eligible to enroll in SCO under 130 CMR 508.008(a) who voluntarily enrolls with a Contractor. A MassHealth member is not enrolled until the enrollment transaction is processed via Medicaid Management Information System (MMIS).

**Enrollee Information** – information about the Contractor for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.5.E**, and an Enrollee handbook that meets the requirements of **Section 2.10.B.7**, and an identification card.

**Emergency Service Programs (ESP)** - Medically Necessary services that are available seven days per week, 24 hours per day, to provide assessment, or treatment, or stabilization, or any combination of these services to any Enrollee who is experiencing a mental health or substance use disorder, or both, including the Emergency Assessment, Medication Management Services, Short Term Crisis Counseling, Short Term Crisis Stabilization Services and Specialing Services as described in **Appendix A**, as applicable, of the Contract.

**Enrollee Services Representative** - an employee of the Contractor who assists Enrollees with questions and concerns.

**Executive Office of Elder Affairs (EOEA)** - the Secretariat that administers the Massachusetts Home Care Program, Title III, and social and nutrition services under the Older Americans Act, and fulfills advocacy, planning, and policy functions on behalf of the seniors in Massachusetts.

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

**Fiscal Intermediary (FI)** – an entity contracting with EOHHS to perform functions that support an Enrollee’s employment of PCAs, such as withholding, filing, and payment of federal and state taxes and purchase of worker’s compensation insurance (see 130 CMR 422.419), as well as related administrative tasks, including but not limited to issuing PCA checks.

**Frail Elder Waiver** – CMS Waiver Number MA-0059, a waiver of federal requirements granted to the Commonwealth by the U.S. Department of Health and Human Services under 42 U.S.C. § 1396n(c) that allows MassHealth to pay for home and community-based services for MassHealth members who meet MassHealth criteria for Nursing Facility services but continue to reside in the community and agree to receive a waiver service.

**Fraud** - an intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of Provider fraud include, but are not limited to: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and Providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include, but are not limited to, improperly obtaining prescriptions for controlled substances and card sharing.

**Functional Status** – using the Comprehensive Assessment tool prescribed by MassHealth, measurement of the ability of individuals to perform Activities of Daily Living (ADLs) (for example, mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and Instrumental Activities of Daily Living (IADLs) (for example, meal preparation, laundry, and grocery shopping).

**Geriatric Model of Care** - an interdisciplinary approach to provide assessment, prevention, treatment, and other interventions that minimize disability, to promote positive health behaviors, and to maintain health status and function for Enrollees.

**Geriatric Support Services Coordinator (GSSC)** - an employee of an ASAP who meets the qualifications as defined by EOEA to deliver the services listed in **Section 2.4.A.5** of the Contract.

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

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

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

**Incident Report** – a written report concerning an allegation of abuse, neglect, or exploitation of an Enrollee that the Contractor must submit to EOHHS pursuant to **Section 2.9.C.4.i** of this Contract.

**Indian Enrollee** – an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 USC 1603(c)).

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

**Individualized Plan of Care (IPC)** - a detailed written description of the scope, frequency, and duration, of all Covered Services to be provided by the Contractor to the Enrollee as described in **Section 2.4.A.2** of this Contract.

**Initial Assessment** – A comprehensive assessment of an Enrollee that includes: (1) an evaluation of clinical status, Functional Status, nutritional status, and physical well-being; (2) the medical history of the Enrollee, including relevant family members and illnesses; (3) screenings for mental-health status and tobacco, alcohol and drug use; and (4) an assessment of the Enrollee’s need for long term-services and supports, including the availability of informal support. EOHHS may prescribe the Initial Assessment tool.

**Long-Term Services and Supports (LTSS)** – The services and supports set forth in **Appendix A-2**. These services help certain members meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

**MassHealth** - the medical assistance and benefit programs administered by the Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act (42 USC 1396), M.G.L. c. 118E, and other applicable laws and regulations (Medicaid).

**MassHealth Member** - for this Contract, a person who is age 65 or over, enrolled in MassHealth, and eligible for MassHealth Standard.

**MassHealth Standard** - a MassHealth coverage type that offers a full range of Medicaid health benefits to eligible MassHealth Members.

**Medicare** - Title XVIII of the Social Security Act, federal health insurance program for people age 65 and older, certain younger disabled people, and people with kidney failure. Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

**Medicare Advantage** - the Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at Part C, and 42 CFR §422.

**Medically Necessary or Medical Necessity** – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

**Network Provider** – see Provider, defined herein.

**Nursing Home Certifiable (NHC)** - the determination that an Enrollee residing in the community has been found to meet the MassHealth medical eligibility criteria for payment for nursing facility care (see 130 CMR 456).

**Ombudsperson** –a neutral person who assists Enrollees or their designees regarding information, issues, or concerns, related to SCO Contractor’s plan. The Ombudsman will fulfill both individual and systemic advocacy roles, as defined in the contract between EOHHS and the entity administering the Ombudsman program, for individuals enrolled in the Contractor’s plan.

**Ongoing Assessment** - a re-evaluation of an Enrollee's health status conducted in accordance with **Section 2.4.A.11** of the Contract. An Ongoing Assessment for an Enrollee identified as having Complex Care Needs must be conducted in person by a Registered Nurse. EOHHS may prescribe the Ongoing Assessment tool.

**Opt-In Enrollment** – enrollment in a SCO plan initiated by an Eligible Individual.

**Opt Out** – a process by which an Eligible Individual or his/her Authorized Representative chooses not to be enrolled with the Contractor via Passive Enrollment. An Eligible Individual may Opt Out at any time before the effective date of his or her Passive Enrollment.

**Other Provider Preventable Condition (OPPC)** – a condition that meets the requirements of an “Other Provider Preventable Condition” pursuant to 42 CFR 447.26(b). OPPCs may occur in any health care setting and are divided into two sub-categories:

#### National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 CFR 447.26(b) and consist of the following:

##### Wrong surgical or other invasive procedure performed on a patient;

##### Surgical or other invasive procedure performed on the wrong body part;

##### Surgical or other invasive procedure performed on the wrong patient;

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

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

**Outreach** - marketing, including the use of promotional materials, produced in any medium, targeted to Potential Enrollees to promote the Contractor’s program and the use of notification forms and materials to communicate with current Enrollees.

**Passive Enrollee** – An individual selected for enrollment with the Contractor through the Passive Enrollment process.

**Passive Enrollment** – An Enrollment process through which an Eligible Individual is enrolled by EOHHS (or its vendor) with a Contractor following a minimum 60-day advance notification period during which the Eligible Individual may elect to make a different enrollment decision (including Opting-Out or enrolling with a different Senior Care Organization).

**Personal Care Attendant (PCA)** – a person who meets the requirements described in 130 CMR 422.411(A)(1) who is hired by the Enrollee (or a representative of the Enrollee) who provides physical assistance to the Consumer with activities of daily living (as described in 130 CMR 422.410 (A)) or instrumental activities of daily living (as described in 130 CMR 422.410(B)).

**Personal Care Management Agency (PCM Agency)** – a public or private agency under contract with the Contractor to provide PCM Services to an Enrollee in accordance with 130 CMR 422.000.

**Personal Care Management Services (PCM Services)** – services provided by a PCM Agency to an Enrollee, including, but not limited to, those services identified in 130 CMR 422.419(A).

**Potential Enrollee** - a MassHealth Member who may voluntarily elect to enroll in the Senior Care Options Program, but is not yet an Enrollee.

**Prevalent Languages** – As determined by EOHHS, those languages spoken by a significant percentage of Enrollees in each Region in which the Contractor is contracted by EOHHS to operate. EOHHS has determined the current Prevalent Languages spoken by MassHealth Enrollees are Spanish and English. EOHHS may identify additional or different languages as Prevalent Languages at any time during the term of the Contract.

**Primary Care** - the provision of coordinated, comprehensive medical services on both a first-contact and a continuous basis to an Enrollee. The provision of Primary Care incorporates an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

**Primary Care Provider (PCP)** - A practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the SCO and responsible for providing and coordinating the Enrollee’s health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners, physician assistants or physicians who meet the primary care qualifications requirements for Primary Care Providers in **Section 2.5.C.2** of the Contract.

**Primary Care Team (PCT)** - shall have the meaning ascribed to that term by M.G.L. c. 118E, § 9D(a). To assure effective coordination and delivery of care, the PCT may be enlarged at the discretion of the PCP to include other professional and support disciplines.

**Provider** - an appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor for the delivery of Covered Services.

**Provider Network** - the collective group of health care and social support Providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, GSSCs, specialty Providers, mental health/substance abuse Providers, community and institutional long term care Providers, pharmacy Providers, and acute hospital and other Providers employed by or under subcontract with the Contractor. (See **Appendix C** of the Contract.)

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

**Quality Management Goals** - annual goals negotiated by the Contractor and EOHHS to improve the Contractor’s performance under the Contract. Improvement Goals are incorporated into **Section 2.9** of the Contract.

**Rate Cells (also known as Rating Categories) (RCs)** - the categories used by MassHealth to calculate capitation payments. MassHealth RCs take into account clinical status and whether the Enrollee resides in or outside Greater Boston. The RC system includes payment for institutional and community-based Enrollees. Institutional and community groups are further divided according to the specific clinical needs and status of Enrollees. In addition each rate cell is defined differently for Eligible Enrollees who receive both Medicare Parts A & B and MassHealth and those who only receive MassHealth.

**Secretary** – the Secretary of the U.S. Department of Health and Human Services or the Secretary’s designee.

**Senior Care Options Program** - a program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for eligible Massachusetts seniors managed by a SCO using a Geriatric Model of Care.

**Senior Care Organization (SCO)** – the Contractor.

**Service Area** - the specific geographic area of Massachusetts for which the Contractor agrees to provide Covered Services to all Enrollees residing within that geographic area and who select the Contractor. The Contractor’s Service Area is described in **Appendix H**.

**Service Authorization Request** – an Enrollee’s request for the provision of a service.

**State** – the Commonwealth of Massachusetts.

**Subcontractor** - an individual or entity that enters into an agreement with the Contractor to fulfill an obligation of the Contractor under this Contract.

**Long Term Services and Supports Third Party Administrator (LTSS TPA)** – an organization designated by EOHHS to deliver a variety of administrative services to EOHSS to support the administration of the MassHealth long term services and supports programs, including program integrity, claims services, utilization management, quality benchmarking and management, electronic visit verification, and program analytics and reporting.

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

# CONTRACTOR RESPONSIBILITIES

Through the Senior Care Options Program, EOHHS, in coordination with CMS, offers MassHealth seniors the option of enrolling with a SCO, which consists of a comprehensive network of health and social service Providers. Each SCO will deliver and coordinate all components of Medicare and MassHealth Covered Services for Enrollees.

## Compliance

### On-Site Readiness Review

Prior to commencing an initial enrollment of MassHealth Members, the Contractor must successfully complete an on-site readiness review, which will include an assessment of the Contractor’s ability and capacity to perform satisfactorily in each of the areas set forth in 42 CFR 438.66(d)(4), and demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs Plan for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority for each county or region to be served by the Contractor. Failure on the part of the Contractor to demonstrate this designation or to successfully complete an on-site readiness review will be grounds for contract termination pursuant to **Section 5.7**.

### Compliance with Applicable Law

The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as well as the implementing regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as well as the implementing regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act as amended; the Assisted Suicide Funding Restriction Act of 1997; Medicare Advantage program requirements in Part C and Part D of Title XVIII of the Social Security Act and 42 CFR Part 422; Titles XIX and XXI of the Social Security Act and waivers thereof; Chapter 141 of the Acts of 2000 and applicable regulations; Chapter 58 of the Acts of 2006 and applicable regulations; 42 CFR Part 438; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations; and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, including but not limited to section 1557 of such Act, to the extent such provisions apply and other laws regarding privacy and confidentiality, and as applicable, the Clean Air Act, Federal Water Pollution Control Act, and the Byrd Anti-Lobbying Amendment.

### Mental Health Parity Law

In accordance with 130 CMR 450.117(J), the Contractor shall review its administrative and other practices, including the administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law; regulations, including subpart K of 42 CFR 438; and guidance; and submit a certification of compliance to EOHHS in accordance with 130 CMR 450.117(J)(1) and any additional instructions provided by EOHHS.

The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

### Outpatient Drugs

Pursuant to 42 U.S.C. § 1396b(m)(2)(A)(xiii), covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate required by the agreement entered into under 42 U.S.C. § 1396r–8 as the State is subject to and the State shall collect such rebates from manufacturers. The Contractor shall report to the State, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.

The Contractor shall provide outpatient drugs pursuant to this Section in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including, but not limited, to complying with all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

## Contract Management

### Director of the Contractor’s Senior Care Options Program

The Contractor must employ a qualified individual to serve as the Director of its Senior Care Options Program. The Director must be primarily dedicated to the Contractor’s program, hold a senior management position in the Contractor’s organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor’s program.

### SCO Director Responsibilities

The Director must act as a liaison between the Contractor, EOHHS and CMS and have responsibilities that include, but are not limited to, the following:

#### Ensure the Contractor’s compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

#### Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor’s response to the SCO RFR and approved by EOHHS and CMS;

#### Oversee all activities by the Contractor and its Subcontractors, including but not limited to, coordinating with the Contractor’s quality management director, medical director, geriatrician, and behavioral health clinician;

#### Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least 30 days before the intended effective date of the change;

#### Receive and respond to all inquiries and requests made by EOHHS and CMS, in time frames and formats set by EOHHS and CMS;

#### Meet with representatives of EOHHS or CMS, or both, on a periodic or as-needed basis to resolve issues that arise;

#### Ensure the availability to EOHHS or CMS, upon their request, of those members of the Contractor’s staff who have appropriate expertise in each of the operational functions covered under this contract.

#### Attend and participate in director meetings when requested by EOHHS and CMS;

#### Coordinate requests and activities among the Contractor, all Subcontractors, EOHHS, and CMS;

#### Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, EOHHS, or CMS; and

#### Ensure that the Contractor maintain written policies and procedures, including, but not limited to, policies regarding Enrollee rights in accordance with 42 CFR 438.100.

## Enrollment Activities

Enrollment in the Senior Care Options Program is voluntary. For a MassHealth Member to be eligible to enroll in the Senior Care Options Program, the Member must be MassHealth Standard eligible and meet all other eligibility requirements as set forth in 130 CMR 508.008(A).

Medicare eligibility is not a prerequisite for enrollment in the Senior Care Options Program. MassHealth Members with or without Medicare may enroll in the Senior Care Options Program, provided they meet all eligibility requirements as set forth in 130 CMR 508.008(A).

Note: An individual enrolled in Medicare but not eligible for MassHealth Standard (i.e. not a Dual Eligible Senior) is not eligible to enroll in the Senior Care Options Program.

In accordance with **Section 2.1**, prior to commencing the initial enrollment of MassHealth Members, the Contractor must demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs Plan for persons dually eligible for Medicare and Medicaid and has Medicare Part D authority in the counties in which services are to be rendered under this Contract.

### Opt-In Enrollment

The Contractor may submit Opt-In Enrollments to EOHHS on behalf of MassHealth Members eligible for, and seeking to enroll in, the Senior Care Options Program. Prior to submitting such an enrollment to EOHHS, the Contractor shall verify through EOHHS’s electronic on-line Eligibility Verification System (EVS) that the MassHealth Member is MassHealth Standard eligible. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS, and must maintain on file any such forms that have been signed by Enrollees.

### Passive Enrollment

#### EOHHS may conduct Passive Enrollment during the term of the Contract. Individuals who Opt Out will not be included in future Passive Enrollments.

#### The schedule for Passive Enrollment will be determined by EOHHS. EOHHS reserves the right to make changes to the Passive Enrollment schedule at its discretion and at any time.

#### EOHHS will provide notice to each Passive Enrollee at least 60 days prior to the effective date of his or her enrollment with the Contractor.

#### EOHHS will accept Opt Out requests from Passive Enrollees prior to the effective date of enrollment.

#### EOHHS may stop Passive Enrollment in the Contractor’s plan at its discretion, and for any reason, including if the Contractor does not comply with this Contract.

#### EOHHS will monitor Passive Enrollment assignments to all SCO plans, and may make adjustments to the volume and spacing of Passive Enrollment periods at its discretion. In exercising this discretion, EOHHS may consider any factor(s) that it deems relevant, including the capacity of the Contractor, and the capacity of the other SCO plans, to accept potential Passive Enrollees.

### All Enrollments

This **Section 2.3.C** applies to all Enrollments, whether Opt-In Enrollments pursuant to **Section 2.3.A** or Passive Enrollments pursuant to **Section 2.3.B**.

#### Subject to the eligibility requirements set forth in 130 CMR 508.008(A), the Contractor must accept each Enrollee in the order in which he or she seeks to join the Contractor’s plan or is assigned to the Contractor’s plan, without restrictions, regardless of his or her income status, physical or mental condition, age, gender, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing condition(s), health status or expected health status, or need for health care services, in accordance with federal and State requirements.

#### EOHHS will assign Rate Cells (RCs) upon enrollment. For certain RCs, the Contractor must submit a request, including documentation supporting the requested RC. For additional information on RCs, see Section 4.

#### Enrollments received, approved and processed via the MassHealth Medicaid Management Information System (MMIS) by the last business day of the month will be effective on the first calendar day of the following month.

#### The Contractor will be responsible for providing Covered Services to Enrollees from the effective date of enrollment.

#### The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor’s program, including the effective date of enrollment, from CMS and EOHHS systems.

### Primary Care Providers

#### Selection of a Primary Care Provider

Upon enrollment, the Contractor must assist the Enrollee to choose a PCP and assist the Enrollee in selecting a new PCP whenever necessary. If the Enrollee has not selected a PCP by the effective date of enrollment, the Contractor must assign the Enrollee a PCP.

#### Termination of a PCP

When a PCP is terminated from the Contractor’s program, the Contractor must make a good faith effort to give written notification of termination of the PCP, within 15 days after receipt or issuance of the termination notice, to each Enrollee who received his or her Primary Care from, or was seen on a regular basis by, the terminated PCP.

### Initial Assessment

The Contractor must complete an Initial Assessment of the Enrollee within 30 calendar days of the effective date of the Enrollee’s enrollment with the Contractor. The Initial Assessment must include:

#### A face-to-face evaluation of the Enrollee’s clinical status, Functional Status, nutritional status, and physical well-being;

#### The Enrollee’s medical history, including relevant family members and illnesses;

#### A screening of the Enrollee’s mental-health status, and tobacco, alcohol and drug use; and

#### An assessment of the Enrollee’s need for long term services and supports, including the availability of informal support.

### Enrollee Orientation

The Contractor must:

#### Provide an orientation to Enrollees within 30 calendar days of the effective date of enrollment;

#### Make available to family members, significant informal caregivers, and designated representatives, as appropriate, any enrollment and orientation materials upon request;

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

#### Notify its Enrollees:

##### That written information is available in Prevalent Languages;

##### That oral interpretation services are available for any language;

##### How Enrollees can access oral interpretation services; and

##### How Enrollees can access non-written materials described in Section 2.3.F.3 above.

#### Ensure that all orientation materials are provided in a manner and format that may be easily understood, including oral interpretation services in all non-English languages when requested. Orientation materials must include the following:

##### A list of Covered Services;

##### A Provider Network directory;

##### A description of the roles of the PCP and PCT and the process by which Enrollees select and change PCPs including the role of the GSSC for enrollees requiring home and community based services;

##### The Contractor’s Evidence of Coverage (see Appendix B) including, but not limited to, descriptions of:

###### Enrollee rights;

###### An explanation of the Centralized Enrollee Record (CER) and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers (see Section 2.4.A.8-10);

###### How to obtain a copy of the Enrollee’s CER;

###### How to obtain access to specialty, behavioral health, and long term care services;

###### How to obtain services for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area;

###### Information about advance directives (at a minimum, that required by subpart I of 42 CFR 489), designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desires of the Enrollee;

###### How to obtain assistance from ESRs;

###### How to contact the Ombudsperson for assistance in navigating the SCO program and consumer advocacy services;

###### How to file Grievances and Appeals with the Contractor;

###### How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

###### How to obtain assistance with the Medicare and Medicaid Appeals processes through the ESR and external ombudsman; and

###### How to disenroll voluntarily.

### Disenrollment

#### An Enrollee may initiate disenrollment from the Contractor’s program for any reason and at any time.

#### An Enrollee may initiate disenrollment from the Contractor’s program by submitting a request to disenroll either to the State or to the Contractor.

#### The Contractor:

##### Must have a mechanism for receiving timely information about all disenrollments from the Contractor’s program, including the effective date of disenrollment, from CMS and EOHHS systems. Disenrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month;

##### Must be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment;

##### May request that an Enrollee be involuntarily disenrolled for the following reasons *only*:

###### Loss of MassHealth eligibility;

###### Remaining out of the Service Area for more than six consecutive months; or

###### If approved in advance by EOHHS, when the Contractor’s ability to furnish services to the Enrollee or to other Enrollees is seriously impaired; and

##### *May not* request that an Enrollee be involuntarily disenrolled for any of the following reasons:

###### An adverse change in the Enrollee’s health status;

###### The Enrollee’s utilization of medical services;

###### The Enrollee’s diminished mental capacity; or

###### The Enrollee’s uncooperative or disruptive behavior (except when the Enrollee’s continued enrollment seriously impairs the Contractor’s ability to furnish services to the Enrollee or other Enrollees); and

##### Must transfer Enrollee record information to the new Provider upon written request signed by the disenrolled Enrollee; and

##### Must make disenrollment determinations within the timeframe set forth in 42 CFR 438.56(e)(1). In the event that the Contractor fails to make a disenrollment determination within such timeframe, the disenrollment is considered approved.

### Closing Enrollment

The Contractor shall not discontinue or suspend enrollment for Enrollees for any amount of time without 30 calendar days advance notice and the approval of EOHHS.

## Care Management and Integration

### General

#### Service Delivery

The Contractor must authorize, arrange, coordinate and provide all Covered Services for its Enrollees (see Covered Services in **Appendix A**). The Contractor’s provision of Covered Services must comply with the federal regulations for the availability of services as provided in 42 CFR 438.206.

#### Individualized Plan of Care (IPC).

The Contractor must develop for each Enrollee an IPC. The IPC must:

##### Incorporate the results of the Initial Assessment and specify any changes in providers, services, or medications.

##### Be developed by the PCP or PCT under the direction of the Enrollee (and/or the Enrollee’s representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. 422.112(a)(6)(iii) and updated periodically to reflect changing needs identified in Ongoing Assessments. The Enrollee will be at the center of the care planning process.

##### Reflect the Enrollee’s preferences and needs. The Contractor will ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, including the development of the IPC and that the Enrollee receives clear information about:

###### His/her health status, including functional limitations;

###### How family members and social supports can be involved in the care planning as the Enrollee chooses;

###### Self-directed care options and assistance available to self-direct care;

###### Opportunities for educational and vocational activities; and

###### Available treatment options, supports and/or alternative courses of care.

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

##### Include, but is not limited to:

###### A summary of the Enrollee’s health history;

###### A prioritized list of concerns, goals, and strengths;

###### The plan for addressing concerns or goals;

###### The person(s) responsible for specific interventions;

###### The due date for each intervention.

##### The Contractor must:

###### Establish and execute policies and procedures that provide mechanisms by which an Enrollee can sign or otherwise convey approval of his or her ICP when it is developed and at the time of subsequent modifications to it;

###### Inform an Enrollee of his or her right to approve the IPC;

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

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

#### Accepting and Processing Assessment Data

For the purposes of quality management and Rating Category determination, the Contractor must accept, process, and report to EOHHS uniform person-level Enrollee data, based upon an Initial and Ongoing Assessment process that includes ICD-10 diagnosis codes, an assessment as designated by EOHHS, and any other data elements deemed necessary by EOHHS.

#### Assessment and Determination of Complex Care Needs

Upon enrollment, and as appropriate thereafter, the Contractor must perform Initial and Ongoing Assessments. This process will identify all of an Enrollee’s needs, and, in particular, the presence of Complex Care Needs. In performing these assessments, the Contractor must also comply with 42 CFR 438.208(c)(2) through (4) and M.G.L. c. 118E, § 9D(h)(3).

#### Geriatric Support Services Coordinator (GSSC)

##### The Contractor must provide a GSSC to members requiring certain long term services and supports through a contract with one or more of the ASAPs that complies with M.G.L. c. 118E, § 9D. The regions served by the ASAP and the ASAP’s qualification to deliver GSSC services shall be determined by EOEA. If more than one ASAP is operating in the Contractor’s Service Area, the Contractor may:

###### Contract with all of the ASAPs; or

###### Contract with a lead ASAP to coordinate all the GSSC work in the Contractor’s Service Area.

##### The GSSC is responsible for:

###### All of the activities set forth in M.G.L. c. 118E, § 9D(h)(2), which consist of:

Arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other primary care team members designated by the Contractor;

Coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing, home-delivered meals and transportation services;

Monitoring the provision and outcomes of community long-term care and support services, according to the enrollee's service plan, and making periodic adjustments to the enrollee's service plan as deemed appropriate by the primary care team;

Tracking enrollee transfer from one setting to another; and

Scheduling periodic reviews of enrollee care plans and assessment of progress in reaching the goals of an enrollee's care plan.

###### Other care management related activities as may be determined and contracted for by the Contractor.

##### If there is only one ASAP operating in the Contractor’s service area and the Contractor identifies any of the following deficiencies in the performance of the ASAP with which it has contracted, the Contractor must follow the procedure in Section 2.4.A.5.e.

###### The ASAP does not meet its responsibilities relating to the performance of GSSC functions and GSSC qualifications established by the Contractor;

###### The ASAP does not satisfy clinical or administrative performance standards, based on a performance review evaluation by the Contractor and subsequent failure by the ASAP to correct documented deficiencies; or

###### The ASAP meets its basic responsibilities relating to the performance of GSSC functions and GSSC qualifications established by the Contractor, but is substantially less qualified than other ASAPs.

##### The Contractor and an ASAP may enter into any appropriate reimbursement relationship for GSSC services, such as fee-for-service reimbursement, capitation, or partial capitation. If the Contractor is unable to execute or maintain a contract with any of the ASAPs operating in its Service Area due to lack of agreement on reimbursement-related issues, the Contractor must collaborate with EOHHS and EOEA to explore all reasonable options for reconciling financial differences, before terminating or failing to initiate a contract. If the Contractor fails to execute a contract with an ASAP operating in its service area, or determines that it must terminate a contract with an ASAP, and that is the only ASAP operating in its service area, the Contractor must follow the procedure in Section 2.4.A.5.e. The Contractor will cooperate with EOHHS and the Executive Office of Elder Affairs to ensure any claims submitted by the ASAPs are accepted and processed through a standardized system. The Contractor must ensure GSSC services are not duplicated by other care management functions delivered by the Contractor, Providers or other subcontractors and that care management is only counted once for each member in the Medicaid-only MLR calculation, as that term is defined in Section 2.13.Q.1.

##### If the Contractor has identified any of the deficiencies set forth in Section 2.4.A.5.c; is unable to execute a contract with an ASAP; or determines that it must terminate a GSSC contract with an ASAP, and that is the only ASAP that operates in the Contractor’s Service Area; the Contractor must notify EOHHS in writing, within five business days of the triggering event, with detailed specific findings of fact that indicate the deficiencies. If EOHHS finds that the Contractor’s reasons are not substantiated with sufficient findings, EOHHS will develop a corrective action plan for the Contractor that ensures continuation of GSSC services and specifies the actions the Contractor will take.

##### Nothing in this Section 2.4.A.5 precludes the Contractor from entering into a subcontracting relationship with any ASAP for functions beyond those required by M.G.L. c. 118E § 9D, including, but not limited to:

###### Providing community-based services, such as homemaker, chore, and respite services;

###### Performing initial and on-going assessments; and

###### Conducting risk-assessment and care-planning activities regarding non-medical service needs of Enrollees without Complex Care Needs.

#### Integration and Coordination of Services

##### The Contractor must ensure effective linkages of clinical and management information systems among all Providers in the Provider Network, including clinical Subcontractors (that is, acute, specialty, behavioral health, and long term care Providers). The Contractor must ensure that the PCP or the PCT integrates and coordinates services including, but not limited to:

###### An IPC, as described in Section 2.4.A.2 of this Contract;

###### Written protocols for generating or receiving referrals and for recording and tracking the results of referrals;

###### Written protocols for providing or arranging for second opinions, whether in or out of the Provider Network;

###### Written protocols for sharing clinical and IPC information, including management of medications;

###### Written protocols for determining conditions and circumstances under which specialty services will be provided appropriately and without undue delay to Enrollees who do not have established Complex Care Needs;

###### Written protocols for obtaining and sharing individual medical and care planning information among the Enrollee’s caregivers in the Provider Network, and with CMS and EOHHS for quality management and program evaluation purposes;

###### Coordinating the services the Contractor furnishes to the Enrollee between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stay; and

###### Coordinating services provided by the Contractor with the services:

The Enrollee receives from any other managed care entity;

The Enrollee receives in fee-for-service Medicaid; and

The Enrollee receives from community and social support providers.

##### The Contractor shall ensure that each Enrollee receives the contact information for the person or entity primarily responsible for coordinating the Enrollee’s care and services, whether that is the PCP or his or her designee on the PCT.

#### Coordinating Access for Emergency Conditions and Urgent Care Services

The Contractor must ensure linkages among the PCP, the PCT, and any appropriate acute, long term care, or behavioral health Providers to keep all parties informed about utilization of services for Emergency Conditions and Urgent Care. The Contractor may not require advance approval for the following services:

##### Any services for Emergency Conditions;

##### Emergency behavioral health care;

##### Urgent Care sought out of the Service Area;

##### Urgent Care under unusual and extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;

##### Direct-access women’s services; and

##### Out-of-area renal dialysis services.

#### Centralized Enrollee Record (CER)

To coordinate care, the Contractor must maintain a single, centralized, comprehensive record that documents the Enrollee's medical, functional, and social status. The Contractor must make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The organization and documentation included in the CER must meet all applicable professional requirements. The CER must contain the following:

##### Enrollee identifying information;

##### Documentation of each service provided, including the date of service, the name of both the authorizing Provider and the servicing Provider (if different), and how they may be contacted;

##### Multidisciplinary assessments, using the assessment tool designated by EOHHS, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate Provider;

##### Laboratory and radiology reports;

##### Reconciled medication list;

##### Prescribed medications, including dosages and any known drug contraindications;

##### Reports about the involvement of community agencies that are not part of the Provider Network, including any services provided;

##### Documentation of contacts with family members and persons giving informal support, if any;

##### Physician orders;

##### Disenrollment agreement, if applicable;

##### Enrollee’s individual advance directives and health care proxy, recorded and maintained in a prominent place;

##### Plan for Emergency Conditions and Urgent Care, including identifying information about any emergency contact persons; and

##### Allergies and special dietary needs

##### Documentation of Initial and Ongoing Assessments; including verification that an Enrollee has received services for which Providers have billed the Contractor and in accordance with Section 2.4.A.11.b.iv.

#### Requirements for CER Information

##### The Contractor shall, at a minimum, comply with, and require Providers to comply with, all statutory and regulatory requirements applicable to CER Information and other Enrollee medical records. In addition, the CER shall, at a minimum:

###### Be maintained in a manner that is current, detailed, and organized and that permits effective patient care and quality review;

###### Include sufficient information to identify the Enrollee, date of encounter and pertinent information which documents the Enrollee's diagnosis;

###### Describe the appropriateness of the treatment/services, the course and results of the treatment/services; and

###### Be consistent with current professional standards for providing the treatment/services, as well as systems for accurately documenting the following:

Enrollee information;

Clinical information;

Clinical assessments;

Treatment plans;

Treatment/services provided;

Contacts with Enrollees’ family, guardians, or significant others; and

Treatment outcomes.

##### The Contractor shall implement systems to ensure that the CER is:

###### Updated in a timely manner by each Provider of care;

###### Available and accessible 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care Providers for Emergency Conditions and Urgent Care; and

###### Available and accessible to specialty, long term care, and mental health and substance abuse Providers.

##### The Contractor shall provide a copy of the CER at EOHHS’ request for the purpose of monitoring the quality of care provided by the Contractor in accordance with federal law (e.g. 42 USC 1396a(a)(30)) or for the purpose of conducting performance evaluation activities of the Contractor as described under this Contract. The Contractor shall provide such record(s) within 10 days of EOHHS’s request, provided however, that EOHHS may grant the Contractor up to 30 days from the date of EOHHS’s initial request to produce such record(s) if the Contractor specifically requests such an extension and where EOHHS reasonably determines that the need for such record(s) is not urgent and the Contractor is making best efforts to produce such record(s) in a timely fashion.

#### Confidentiality of CER Information

The Contractor must have and comply with written policies to ensure the confidentiality of CER information. Such policies must include the following:

##### At a minimum, complying with all federal and State legal requirements as they pertain to confidentiality of Enrollee records, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 CFR parts 160 and 164, M.G.L. c. 66A, and, if applicable, M.G.L. c. 123 §36;

##### Informing Enrollees how to obtain a copy of their CER and how to request that it be amended or corrected;

##### Requiring all Subcontractors to abide by the confidentiality protections established by the Contractor;

##### Ensuring that documentation of mental health and substance abuse treatment in the CER includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed (psychotherapeutic session notes must not be recorded in the CER);

##### Providing records at the request of EOHHS or CMS, or both, for monitoring the quality of care provided by the Contractor in accordance with federal law (for example, 42 USC 1396a (a) (30)) and conducting performance evaluation activities; and

##### Auditing all access to records to ensure that only authorized individuals have access to information to prevent misuse.

#### Frequency of Assessments

The Contractor must:

##### Complete an Initial Assessment within 30 calendar days of the effective date of enrollment. In the event that the Contractor’s initial attempts to contact the Enrollee are unsuccessful, the Contractor shall make subsequent attempts to conduct the initial screening;

##### Schedule and perform Ongoing Assessments, utilizing an assessment tool approved by EOHHS, of each Enrollee’s needs:

###### At least once every six months, or

###### At least quarterly for Enrollees who require Complex Care and it is to be performed by a member of the Enrollee’s PCT, or

###### Whenever an Enrollee experiences a major change that is:

Not temporary;

Impacts more than one area of health status; and

Requires interdisciplinary review or revision of the Individualized Plan of Care.

###### The Contractor shall have a process in place to verify Enrollee receipt of services for which Providers have billed the Contractor. This verification of covered services shall be documented in the CER in accordance with Section 2.4.A.8.n.

##### In accordance with professional standards, record the results of all assessments in the CER; and

##### In accordance with professional standards, share the results of any identification and assessment of the Enrollee’s needs with MassHealth, other managed care entities serving the Enrollee, and the Enrollee’s provider network in a timely manner to prevent duplication of those activities.

#### Coordinating Services with Federal, State, and Community Agencies

##### The Contractor must implement a systematic process for coordinating care and creating linkages for services for its Enrollees with organizations not providing Covered Services including, but not limited to:

###### State agencies (for example, EOEA, the Department of Public Health, the Department of Developmental Services, and the Department of Mental Health);

###### Social service agencies (such as the Councils on Aging) and services (such as housing, food delivery, and non-medical transportation);

###### Consumer, civic, and religious organizations; and

###### Federal agencies (for example, the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

##### The systematic process and associated linkages must provide for:

###### Sharing information and generating, receiving, and tracking referrals;

###### Obtaining consent from Enrollees to share individual Enrollee medical information where necessary; and

###### Ongoing coordination efforts (for example, regularly scheduled meetings, newsletters, and joint community-based projects).

##### Pursuant to 42 CFR § 438.3(t), the Contractor shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process.

#### Consumer Participation on Governing and Advisory Boards

The Contractor must obtain Consumer and community input on issues of program management and participant care. At least one Consumer shall serve on the Contractor’s governing board. The Contractor must also establish at least one Consumer advisory committee and a process for that committee to provide input to the governing board.

#### Authorization of Services

In accordance with 42 CFR 438.210, the Contractor and its Subcontractors, if applicable, must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services to ensure consistent application of review criteria for authorization decisions. In connection with the processing of such requests, the Contractor shall consult with the requesting Provider when appropriate. These written policies and procedures shall require that:

##### The GSSC shall have all of the responsibilities set forth in Section 2.4.A.5;

##### Any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in addressing the Enrollee’s medical, behavioral health, or long-term services and supports needs;

##### Decisions for authorization of services and related notices be issued as expeditiously as the Enrollee’s health condition requires but no later than 14 days after the receipt of the request for service. The Contractor may extend the 14 day deadline by up to 14 additional calendar days if the Enrollee requests the extension or if the Contractor justifies a need for additional information and how the delay is in the interest of the Enrollee. When the Contractor extends the deadline, it must notify the Enrollee in writing of the reasons for the delay and inform the Enrollee of the right to file a Grievance if he or she disagrees with the Contractor’s decision to grant an extension. The Contractor must notify the Enrollee of its determination as expeditiously as the Enrollee's health condition requires, but no later than upon expiration of the extension;

##### In the event a Provider indicates, or the Contractor determines, that the timeframe described at Section 2.4.14.c. could seriously jeopardize an Enrollee’s life or health or ability to attain, maintain or regain maximum function, the Contractor must make a service authorization decision and provide notice to the Enrollee as expeditiously as the Enrollee’s health condition requires but no later than 72 hours after the receipt of the request for service;

##### In addition to the requirements imposed by law and regulation – including but not limited to 130 CMR 450.117(J)(2) – the Contractor and any of its subcontractors with prior authorization authority, must provide medical necessity criteria for authorization of services upon the request of an Enrollee, a Network Provider, or the MassHealth agency. This requirement may be fulfilled by publishing the criteria on the Contractor’s website; and

##### For all covered outpatient drug authorization decisions, the Contractor shall provide notice as described in Section 1927(d)(5)(A) of the Social Security Act.

#### Utilization Management Activities

If the Contractor provides compensation to individuals or entities to conduct utilization management activities, compensation for these activities must not be structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any Enrollee.

### Primary, Acute, and Preventive Care

#### PCP Clinical Responsibilities

The PCP must:

##### Provide overall clinical direction and serve as a central point for the integration and coordination of the Covered Services listed in Appendix A. For individuals with Complex Care Needs, a PCT must be created and the PCP must participate as needed (see Section 2.4.B.2; and

##### Assume clinical responsibility for each Enrollee upon the effective date of enrollment including, but not limited to:

###### Making an initial clinical determination of Emergency Conditions, Urgent Care, or routine Enrollee status;

###### Providing for the transition of existing services, equipment, and other resources to ensure safe, efficient continuity of care at enrollment;

###### Providing primary medical services, including acute and preventive care; and

###### Referring the Enrollee to specialty, long term care, and behavioral health Providers, as medically appropriate.

#### Care Management Responsibilities of the PCP or his or her designee on the PCT.

As the manager of care, the PCP or the PCP’s designee must:

##### With the Enrollee and the Enrollee’s designated representative, if any, develop an IPC;

##### In the presence of Complex Care Needs, implement a comprehensive evaluation process to be performed by a PCT, which will include an in-home or in-facility component. Enrollees with Complex Care Needs will have their care managed by a PCT;

##### On an ongoing basis, consult with and advise acute, specialty, long term care, and behavioral health Providers about care plans and clinically appropriate interventions;

##### Conduct Ongoing Assessments appropriately and, as required in this Contract, adjust Individualized Plans of Care as necessary and with enrollee’s knowledge, and communicate the information to the Enrollee’s Providers in timely manner;

##### With the assistance of the GSSC, if any, promote independent functioning of the Enrollee and provide services in the most appropriate, least restrictive environment;

##### Document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions;

##### Assist in the designation of a health care proxy, if the Enrollee wants one;

##### Maintain the CER, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee (see Section 2.4.A.8-10; and

##### Communicate with the Enrollee, and the Enrollee’s family members and significant caregivers, if any and as appropriate under HIPAA, about the Enrollee's medical, social, and psychological needs.

### Long Term Care

#### Long Term Care Delivery System

In delivering the Covered Services referenced in **Appendix A** that relate to long term care services, the Contractor must demonstrate the capacity to provide coordination of care and expert care management through the PCT. The Contractor must ensure that:

##### The PCT arranges, delivers, and monitors long term care services on an ongoing basis; and

##### The measurement of the Functional Status of Enrollees is performed at Initial and Ongoing Assessments. Reports will be produced in accordance with Section 2.13.E.

#### Continuum of Long Term Care

The Contractor must arrange and pay for:

##### Community alternatives to institutional care (see Appendix A);

##### Other transitional, respite, and residential support services to maintain Enrollees safely in the community, based on assessment by the Contractor of Functional need and cost effectiveness of the services being requested;

##### Nursing facility services for Enrollees who meet applicable screening requirements (in accordance with 130 CMR Chapter 456 and Chapters 515 through 524) and for whom the Contractor has no community service package appropriate and available to meet the Enrollee’s medical needs; and

##### Other institutional services as determined by the PCT.

#### Pre-Admission Screening and Resident Review (PASRR) Evaluation

The Contractor must comply with federal regulations requiring referral of nursing facility eligible Enrollees, as appropriate, for PASRR evaluation for mental illness and developmental disability treatment pursuant to the Omnibus Budget Reconciliation Act of 1987, as amended, and 42 CFR 483.100 through 483.138.

### Behavioral Health

#### Systematic Early Identification and Intervention for Behavioral Health Services

Behavioral health conditions must be systematically identified and addressed by the Enrollee's PCP or PCT at the Initial and Ongoing Assessments through the use of appropriate mental-health screening tools as designated or approved by EOHHS. When appropriate, the Contractor must ensure that referrals for specialty behavioral health services are made promptly, monitored, and documented in the CER.

#### Services for Enrollees with Serious and Persistent Mental Illness

The Contractor must ensure that Enrollees with serious and persistent mental illness have access to ongoing medication review and monitoring, day treatment, and other milieu alternatives to conventional therapy. The PCT must coordinate services with additional support services the member may be receiving, including but not limited to services provided by or through state agencies such as DMH or DDS, as appropriate. For such Enrollees, a qualified behavioral health clinician (see **Section 2.5.B**) must be part of the PCT. As necessary, care coordination with the Department of Mental Health must be provided.

#### Continuum of Behavioral Health Care

The Contractor must offer a continuum of behavioral health care that is coordinated with PCPs or PCTs, as appropriate, and includes but is not limited to:

##### A range of services from acute inpatient treatment to intermittent professional and supportive care for delivering behavioral health services to Enrollees residing in the community or in nursing facilities; and

##### Diversionary services that offer safe community alternatives to inpatient hospital services. (See Appendix A.)

#### Behavioral Health Responsibilities

The Contractor must manage the provision of all behavioral health services. When services for Emergency Conditions are needed, the Enrollee may seek care from any qualified behavioral health Provider. The care-management protocol for Enrollees must encourage appropriate access to behavioral health care in all settings. For Enrollees who require behavioral health services, the behavioral health Provider must:

##### With the Enrollee and the Enrollee’s designated representative, if any, develop the behavioral health portion of the IPC for each Enrollee in accordance with accepted clinical practice. The IPC must be signed or otherwise approved by the Enrollee or the Enrollee’s designated representative, if any;

##### With the input of the PCP or PCT, as appropriate, determine clinically appropriate interventions on an on-going basis, with the goal of promoting the independent functioning of the Enrollee;

##### Make appropriate and timely entries into the CER about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and Individualized Plan of Care developed. As stated in Section 2.4.A.10.d, psychotherapeutic session notes must not be recorded in the CER; and

##### Obtain authorization from the PCP or PCT, as appropriate, for any non-emergency services, except when authorization is specifically not required under this Contract.

#### Coordination of Medication

Prescriptions for any psychotropic medications must be evaluated for interactions with the medications already prescribed for the Enrollee. (See **Section 2.13.A.2**.)

#### Behavioral Health Needs Management

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

#### The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services set forth in Appendix A as most recently adopted by the American Medical Association and CMS; and shall pay no less than the MassHealth rate for such CPT codes.

#### Substance Use Disorder Services

##### Prior authorization shall not be required for the following services:

###### Inpatient Substance Use Disorder Services (Level IV), as defined in Appendix A, Exhibit 1;

###### Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7), as defined in Appendix A, Exhibit 1;

###### Clinical Support Services (CSS), as defined in Appendix A, Exhibit 1, for Substance Use Disorders (Level III.5). The Contractor may implement utilization review procedures on the seventh day of a patient’s stay for CSS, but shall not make any utilization review decisions that impose any restriction or deny any future medically necessary CSS unless a patient has received at least 14 consecutive days of CSS;

###### The following Outpatient Services: Counseling (including Couples/Family Treatment, Group Treatment, and Individual Treatment) and Ambulatory Detoxification, as defined in Appendix A, Exhibit 1;

###### The following Non-24-Hour Diversionary Services: Structured Outpatient Addiction Program (SOAP), as defined in Appendix A, Exhibit 1;

###### Intensive Outpatient Program (IOP), as defined in Appendix A, Exhibit 1;

###### Partial Hospitalization as defined in Appendix A, Exhibit 1, with short-term day or evening mental health programming available seven days per week; and

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

##### Providers providing Clinical Support Services for Substance Use Disorders (Level III.5) and Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) shall provide the Contractor, within 48 hours of an Enrollee’s admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Enrollee, information regarding the Enrollee’s coverage with the Contractor, and the provider’s initial treatment plan. Contractor may not use failure to provide such notice as the basis for denying claims for services provided. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee.

#### Community Support Program (CSP) Services for Chronically Homeless Individuals

Subject to the Medical Necessity requirements set forth in 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP services as set forth in **Appendix A, Exhibit 1**, **Section B.1** to eligible Enrollees as defined in this section.

##### For purposes of this Section 2.4.D.9, an eligible Enrollee shall be an Enrollee that either (a) received CSP services at the time of enrollment or (b) is Chronically Homeless.

##### The Contractor shall authorize, arrange, coordinate, and provide CSP services, as set forth in Appendix A, Exhibit 1, Schedule B.1, to eligible Enrollees, which shall include, at a minimum:

###### Assisting in enhancing daily living skills;

###### Providing service coordination and linkages;

###### Assisting with obtaining benefits, housing and healthcare;

###### Developing a crisis plan;

###### Providing prevention and intervention; and

###### Fostering empowerment and recovery, including linkages to peer support and self-help groups.

### Health Promotion and Wellness Activities

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

#### Exercise;

#### Preventing falls;

#### Adjustment to illness-related changes in functional ability;

#### Adjustment to changes in life roles;

#### Smoking cessation;

#### Nutrition;

#### Prevention and treatment of alcohol and substance abuse; and

#### Coping with Alzheimer’s disease or other forms of dementia.

### Continuity of Care Period for Passively Enrolled individuals

#### For all Covered Services, the Contractor must develop policies and procedures to ensure continuity of care for all Passively Enrolled Enrollees for at least 90 calendar days after the effective date of each such Enrollee’s enrollment with the Contractor. Unless an Enrollee agrees to the implementation of the IPC prior to the expiration of this 90-day period, during this 90-day period, the Contractor must, at a minimum:

##### Allow Enrollees to remain with their current providers and make payment to such providers at current MassHealth fee-for-service provider rates, even if such providers are not part of the Contractor’s Provider Network;

##### Honor all prescriptions for covered drugs that were issued prior to the completion of the IPC;

##### Honor all prior authorizations that MassHealth issued prior to the completion of the IPC; and

##### Prevent gaps in the provision of Covered Services by ensuring that Enrollees are promptly linked with Network Providers following the completion of the IPC.

##### The Contractor must also notify the provider of the services that the services will no longer be authorized.

#### If, as a result of the development of the IPC or the Initial Assessment, the Contractor proposes modifications to the Enrollee’s prior authorized services, the Contractor must notify the Enrollee, in writing, of his or her opportunity to appeal the proposed modifications. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in Section 2.8 of this Contract.

#### If, prior to Enrollment, an Enrollee is receiving a service that the Contractor will not cover after the end of the 90-day continuity of care period described in Section 2.4.F.1, the Contractor must inform the Enrollee of this fact, in writing, prior to the end of the 90-day continuity of care period, using the procedure set forth at 42 CFR 438.404 and 42 CFR 422.568. Upon receipt of such notice, the Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in Section 2.8 of this Contract.

## Provider Network

### General

#### Through the execution of Provider Agreements, the Contractor must maintain and monitor a Provider Network that is sufficient to provide all Enrollees, including those with limited English proficiency or physical or mental disabilities, with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required under this Contract (see Covered Services in Appendix A). Pursuant to 42 CFR 438.608(b), the Contractor shall ensure that all such providers are enrolled with MassHealth as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR 455, subparts B and E. The Contractor must notify EOHHS of any Provider Network changes that impact Enrollee access to Covered Services within five business days.

#### The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women’s health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women’s routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women’s health specialists as PCPs;

#### At the Enrollee’s request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee;

#### If the Contractor declines to include individuals or groups of Providers in its Provider Network, the Contractor must give the affected Providers written notice of the reason for its decision. Pursuant to 42 CFR 438.12(b) this requirement may not be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees, or preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or to preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs consistent with its responsibilities to Enrollees.

#### The Contractor must comply with all applicable requirements and standards set forth at 42 CFR 422.112; 422 Subpart E; 422.504(a)(6) and 422.504(i); 422 Subpart K, 423 Subpart C; and other applicable federal laws and regulations related to managed care entity relationships with providers and with related entities, contractors and subcontractors for services in the Contractor’s Medicare Advantage Special Needs Plan for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority.

#### The Contractor may use different reimbursement amounts for different specialties and for different practitioners in the same specialty.

#### The Contractor may not employ or contract with Providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act.

#### The Contractor shall ensure that Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract;

#### To support the Contractor’s development of its Provider Network, EOHHS will provide the Contractor with information on Medicaid provider participation, such as through EOHHS’ online provider directory.

#### The Contractor shall assure EOHHS that it has the capacity to service expected enrollment of Enrollees in accordance with the access standards specified in Section 2.5.A and Section 2.6 by submitting the access and availability reports specified in Appendix D.

##### The Contractor must submit these reports on a quarterly basis and whenever there is a significant change in operations that would affect the adequacy and capacity of services. Such significant changes include, but are not limited to:

###### Changes in Covered Services;

###### Enrollment of a new population in the Contractor’s plan;

###### Changes in benefits; and

###### Changes in Network Provider payment methodology.

##### In these reports, the Contractor must demonstrate that it maintains a Provider Network that:

###### Is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in each of the State’s regions;

###### Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports that is adequate for the anticipated number of Enrollees in each of the State’s regions; and

###### Includes sufficient family planning providers to ensure timely access to covered services.

##### If the Contractor does not comply with the access standards specified in Section 2.5.A and Section 2.6, the Contractor shall take corrective action necessary to comply with such access standards.

#### The Contractor may not restrict an Enrollee’s free choice of family planning services and supplies providers.

### Provider Credentialing, Recredentialing, and Board Certification

#### General Provider Credentialing

The Contractor shall implement written policies and procedures that comply with the requirements of 42 CFR 438.214 regarding the selection, retention and exclusion of Providers and meet, at a minimum, the requirements below. The Contractor shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually in accordance with **Appendix D** that all Providers within the Contractor’s Provider Network are credentialed according to such policies and procedures. The Contractor shall:

##### Designate and describe the department(s) and person(s) at the Contractor’s organization who will be responsible for Provider credentialing and re-credentialing;

##### Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Providers and all other licensed or certified Providers who participate in the Contractor’s Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. Such processes shall also be consistent with any uniform credentialing policies specified by EOHHS addressing acute, primary, behavioral health Providers (including but not limited to substance use disorder Providers), and any other EOHHS-specified Providers;

##### Ensure that all Providers are credentialed prior to becoming Network Providers and that a site visit is conducted in accordance with recognized managed care industry standards and relevant federal regulations;

##### Maintain a documented re-credentialing process which shall occur at least every three years (thirty six months) and shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews conducted pursuant to Section 2.9, utilization management information collected pursuant to Section 2.14.B, and Enrollee satisfaction surveys collected pursuant to Section 2.12.C;

##### Maintain a documented re-credentialing process that requires that physician Providers and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards such as those provided by NCQA and relevant state regulations, when obtaining Continuing Medical Education (CME) credits or continuing Education Units (CEUs) and participating in other training opportunities, as appropriate. Such processes shall also be consistent with any uniform re-credentialing policies specified by EOHHS addressing acute, primary, behavioral health Providers (including but not limited to substance use disorder Providers), and any other EOHHS-specified Providers;

##### Upon notice from EOHHS, not authorize any providers terminated or suspended from participation in MassHealth, Medicare or from another state’s Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

###### The Contractor shall monitor Providers and prospective Providers by monitoring all of the databases described in Appendix J, at the frequency described in Appendix J as follows.

The Contractor shall search the databases in **Appendix J** for individual Providers, Provider entities, and owners, agents, and managing employees of Providers at the time of enrollment and re-enrollment, credentialing and recredentialing, and revalidation;

The Contractor shall evaluate the ability of existing Providers, Provider entities, and owners, agents, and managing employees of Providers to participate by searching newly identified excluded and sanctioned individuals and entities reported as described in **Appendix J**;

The Contractor shall identify the appropriate individuals to search and evaluate pursuant to this Section by using, at a minimum, the Federally Required Disclosures Form provided by EOHHS;

The Contractor shall submit a monthly Excluded Provider Monitoring Report to EOHHS, as described in **Appendix D**, which demonstrates the Contractor’s compliance with this section. At the request of EOHHS, the Contractor shall provide additional information demonstrating to EOHHS’ satisfaction that the Contractor complied with the requirements of this Section, which may include, but shall not be limited to computer screen shots from the databases set forth in **Appendix J**; and

The Contractor shall develop and maintain policies and procedures to implement the requirements set forth in this section.

###### If a provider is terminated or suspended from MassHealth, Medicare, or another state’s Medicaid program or is the subject of a state or federal licensing action, the Contractor shall terminate, suspend, or decline a provider from its Network as appropriate.

###### The Contractor shall notify EOHHS when it terminates, suspends, or declines a Provider from its Network because of the reasons described in subsection 2) above or for any other independent action including for a reason described in this section;

###### On an annual basis, the Contractor shall submit to EOHHS a certification checklist set forth in Appendix D confirming that it has implemented the actions necessary to comply with this section; and

###### This section does not preclude the Contractor from suspending or terminating Providers for cause prior to the ultimate suspension and/or termination from participation in MassHealth, Medicare or another state’s Medicaid program;

##### Not employ or contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state’s Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;

##### Not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

##### Ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90;

##### Search and do not contract with the names of parties disclosed during the credentialing process in the databases in Appendix J, in accordance with the Contractor’s obligations set forth in Section 2.5.B.1.f.i, in the MassHealth exclusion list, and parties that have been terminated from participation under Medicare or another state’s Medicaid program. The Contractor shall, as of the date indicated in the exclusion database, not contract with or shall terminate a contract with any provider found in the exclusion database;

##### Obtain federally required disclosures from all Network Providers and applicants in accordance with 42 CFR 455 Subpart B and 42 CFR 1002.3, and as specified by EOHHS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to EOHHS in accordance with this Contract, including this section, and relevant state and federal laws and regulations;

##### Notify EOHHS when a Provider fails credentialing or re-credentialing because of a program integrity reason, including those reasons described in this section, and shall provide related and relevant information to EOHHS as required by EOHHS or state or federal laws, rules, or regulations;

##### Develop and maintain policies and procedures that support a process for the recoupment of payments from Providers identified as excluded by appearing on any exclusion or debarment database, including those at Appendix J. The Contractor shall maintain documentation to support the date and activities by which recoupment efforts are established for claims paid after the date indicated in the exclusion database. At a minimum, the Contractor shall document recoupment efforts include outreach to the Provider, voiding claims, and establishing a recoupment account; and

##### As further directed by EOHHS, share information collected pursuant to the credentialing activities described in this section with EOHHS, including to facilitate EOHHS efforts to standardize Provider enrollment or credentialing processes between EOHHS and the Contractor.

#### Board Certification Requirements

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

##### Require that all applicant physicians, as a condition for participation in the Contractor’s Network, meet one of the following, except as otherwise set forth in paragraph b. below:

###### Be board certified in their practicing medical specialty;

###### Be in the process of achieving initial certification; or

###### Provide documentation demonstrating that the physician either is currently board eligible or has been board eligible in the past.

##### If necessary to ensure adequate access, the Contractor may contract with Providers who have training consistent with board eligibility but are neither board certified nor were ever eligible to be board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address; and

##### Provide a mechanism to monitor participating physician compliance with the Contractor’s board certification requirements, including, but not limited to, participating physicians who do not achieve board certification eligibility.

#### Behavioral Health Provider Credentialing

##### In addition to those requirements described in Section 2.5.B.1-2 above, the Contractor shall implement the Behavioral Health Credentialing Criteria as prior approved by EOHHS;

##### Meet or exceed all of the requirements of this Contract with regard to Behavioral Health Credentialing Criteria and Behavioral Health Clinical Criteria;

##### For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, ensure that such hospital has a human rights protocol that is consistent with the DMH requirements and regulations and includes training of the Behavioral Health Provider’s staff and education for Enrollees regarding human rights; and

##### For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, ensure that such hospital has a human rights officer who shall be overseen by a human rights committee, and shall provide written materials to Enrollees regarding their human rights, in accordance with DMH regulations and requirements.

#### Laboratory Credentialing

The Contractor shall require, in accordance with the Clinical Laboratory Improvement Amendments (CLIA), all laboratories performing services under this Contract to:

##### Have a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by the U.S. Department of Health and Human Services applicable to the category of examinations or procedures performed by the laboratory;

##### Be CLIA-exempt as defined in 42 CFR 493.2; or

##### Satisfy an exception set forth in 42 CFR 493.3(b).

### Provider Qualifications and Performance

#### Written Provider Protocols

In addition to the credentialing and re-credentialing processes described above, the Contractor must have and comply with written protocols in the following areas:

##### Practice guidelines, in accordance with 42 CFR 438.236. The Contractor must disseminate such practice guidelines to Enrollees and Potential Enrollees upon request;

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

###### Mechanisms for detecting both underutilization and overutilization of services;

###### Resource utilization of services, including specialty and ancillary services;

###### Clinical performance measures on structure, process, and outcomes of care;

###### Interdisciplinary team performance, including resolution of service plan disagreements;

###### Enrollee experience and perceptions of service delivery; and

###### Timely access.

##### A corrective action process for Providers whose performance is unacceptable in one or more of the areas noted in Section 2.5.C.1.dabove. For serious complaints involving medical Provider errors, the Contractor must take immediate corrective action and file reports of corrections made with the CMS and EOHHS within three business days of the complaint.

#### Primary Care Qualifications

The Enrollee's care will be managed by a PCP or his or her designee on a PCT. The PCP and the members of the PCT must meet the following qualifications.

##### Physician

A physician serving as the PCP must:

###### Be licensed by the Massachusetts Board of Registration in Medicine:

###### Obtain annual continuing medical education units in geriatric practice;

###### Have at least two years’ experience in the care of persons over the age of 65; and

###### Be a Provider in good standing with the federal Medicare program.

##### Registered Nurse or Nurse Practitioner

A nurse practitioner serving as the PCP or registered nurse or nurse practitioner serving as a member of a PCT must:

###### Be licensed by the Massachusetts Board of Registration of Nursing,

###### Obtain annual continuing education units in geriatric practice; and

###### Be certified as a geriatric nurse practitioner or demonstrate at least two years’ professional experience in the care of persons over the age of 65.

##### Physician Assistant:

A physician assistant serving as the PCP or as a member of a PCT must:

###### Be licensed by the Board of Registration of Physician Assistants;

###### Obtain annual continuing education units in geriatric practice; and

###### Demonstrate at least two years’ professional experience in the care of persons over the age of 65.

#### Subcontracting Requirements

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

##### All Subcontracts must be prior approved by EOHHS. To obtain such approval, the Contractor shall make a request in writing and submit with that request a completed Subcontractor checklist using the template provided by EOHHS and attached hereto as Appendix K, and completed federally required disclosure forms (see Appendix G), if required in accordance with Section 2.5.B.1.k, at least 60 days prior to the date the Contractor expects to execute the Subcontract. Among other things required in the checklist, the Contractor must describe the process for selecting the Subcontractor, including the selection criteria used. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the checklist.

##### A GSSC must meet the standards established by the EOEA in designating ASAPs as qualified to serve as GSSCs.

##### The Subcontract shall:

###### Be a written agreement;

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

###### Provide for imposing sanctions, including contract termination, if the Subcontractor’s performance is inadequate;

###### Require the Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and provisions of this Contract;

###### Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the Subcontract requires the Subcontractor to agree that:

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

It will make available, for the purposes of an audit, evaluation or inspection described in this subsection, its premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems relating to its Medicaid Enrollees;

##### The Contractor shall monitor any Subcontractor’s performance on an ongoing basis and perform a formal review annually. If any deficiencies or areas for improvement are identified, the Contractor shall require the Subcontractor to take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result.

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

##### In accordance with Appendix D, the Contractor shall submit to EOHHS an annual list of all Subcontractors. Such annual report shall include notification if any of its Subcontractors are a business enterprise (for-profit) or non-profit organization certified by the Commonwealth’s [Supplier Diversity Office](https://www.sdo.osd.state.ma.us/BusinessDirectory/BusinessDirectory.aspx). The Contractor shall submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the above-mentioned list and report.

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

##### The Contractor shall, pursuant to the Acts of 2014, c. 165, Section 188, file with MassHealth any contracts or subcontracts for the management and delivery of behavioral health services by specialty behavioral health organizations to MassHealth members and MassHealth shall disclose such contracts upon request.

##### Notwithstanding any relationship the Contractor may have with a Subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract; and

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

### Provider Training

The Contractor must:

#### Inform its Provider Network about the program, including all Covered Services contained in Appendix A;

#### Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services through the provision of a Provider-training curriculum, flow charts, and other written materials to enhance coordination and linkage;

#### Inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Appeals (both internal and external);

#### Develop and provide continuing education programs for members of the Provider Network, including but not limited to:

##### Identification and management of depression, alcohol and substance abuse, and dementia including Alzheimer’s disease;

##### Identification and treatment of incontinence;

##### Preventing falls;

##### Identification of abuse and neglect of elderly individuals;

##### Coordination of care within the Provider Network, including instructions regarding policies and procedures for maintaining the CER;

##### The requirements of this contract related to continuity of care; and

##### The NCQA approved model of care required under Social Security Act Section 1859(f)(7) including care management roles and responsibilities of each member of the ICT.

#### Instruct and assist the Providers in the Contractor’s Provider Network in the process and need for verifying each Enrollee’s MassHealth eligibility and enrollment in MassHealth prior to providing any services, and at each point of service, through EOHHS’s electronic on-line Eligibility Verification System (EVS). The Contractor and its Providers shall not require such verification prior to providing Emergency Services and without resulting in discrimination against the Enrollee.

#### The Contractor must include provisions in its contracts with its PCM Agencies requiring that the PCM Agencies instruct Enrollees regarding appropriate utilization of PCA overtime requiring authorization pursuant to 130 CMR 422.418(C), in accordance with 130 CMR 422.421(B)(1)(b)(5). For the avoidance of doubt, any Contractor contracting with a PCM Agency to provide PCM Services shall require such PCM Agency to agree to:

##### Attend trainings as directed by EOHHS;

##### Comply with reporting requirements for PCA services as directed by EOHHS;

##### Respond to Enrollee inquiries regarding overtime management and overtime approval requests;

##### Educate Enrollees that do or may need to schedule PCAs for more than 50 hours per week regarding the scheduling requirements pursuant to 130 CMR 422.420(A)(5)(b) and 130 CMR 422.418(C) and the potential consequences pursuant to 130 CMR 422.420(B)(5);

##### Assist Enrollees that do or may need to schedule PCAs to work more than 50 hours per week by working with those Enrollees to identify additional resources to enable such Enrollees to hire additional PCAs to meet the scheduling requirements;

##### Provide an overtime approval request form for Enrollees who request it, provide related instruction in completing the form to request overtime approval, and work with Enrollees to obtain Enrollee and PCA signatures;

##### Review and submit completed overtime approval request forms within one business day of receipt of said forms to MassHealth in a manner prescribed by MassHealth and maintain the original and related documents, if any, in the Enrollee’s file;

##### Communicate MassHealth’s decisions regarding overtime approval requests within one business day to Enrollees and to the Contractor;

##### Assist Enrollees who are denied overtime approval requests, or Enrollees who are approved for a short-term continuity of care overtime approval requests, by:

###### Working with the Enrollee to identify additional resources to enable Enrollee to hire additional PCAs;

###### Working and communicating with the FI regarding overtime approval requests and decisions;

###### Working and communicating with the Contractor regarding the statuses of Enrollees who have been approved to schedule overtime, Enrollees who have not been approved to schedule overtime but who have applied for an overtime approval, and Enrollees who are not in compliance with the MassHealth overtime scheduling requirements pursuant to 130 CMR 422; and

###### Informing Enrollees about their appeal rights with the MassHealth Board of Hearings pursuant to 130 CMR 610.

##### Receive and maintain lists from FIs that identify Enrollees who employ PCAs that work more than 50 hours per week; and

##### Prioritize the list of existing Enrollees who employ PCAs that work more than 50 hours per week and contact such Enrollees in order of priority to identify and assess each Enrollee’s need for scheduling one or more PCAs for overtime.

Such requirements shall apply to this **Section 2.5.D.6** regardless of whether the PCM Agency also participates in the MassHealth Personal Care Management program.

### Provider Network Directory

The Contractor shall:

#### Develop and make available a Network Provider directory that identifies the Contractor’s Network Providers. The directory shall include each Network Provider’s:

##### Name, as well as any group affiliation;

##### Street address(es);

##### Telephone number(s);

##### Web site URL (if applicable);

##### Specialty(ies) (if applicable);

##### Ability to accept new Enrollees;

##### Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office, and whether the provider has completed cultural competence training;

##### Office’s/facility’s accommodations for people with physical disabilities, including offices, exam room(s), and equipment;

##### Office hours;

##### For behavioral health providers, licensing information;

##### Accessibility by public transportation;

##### Special experience, skills, training, and/or expertise in treating:

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

###### Homeless persons;

###### Persons with co-occurring mental health and substance abuse conditions (also known as “Dual Diagnosis”); and

###### Other specialties.

#### Maintain the Network Provider directory required by this section in both electronic and paper form as follows:

##### Paper Version – The Contractor shall update its paper provider directory at least monthly.

##### Electronic Version – The Contractor shall maintain an up-to-date version of the Network Provider Directory on the Contractor’s website that is available to the general public. The Contractor shall update this electronic directory no later than 30 calendar days after the Contractor receives updated provider information. The Contractor shall maintain this electronic directory in a machine-readable file and format. At a minimum, the Contractor shall maintain this electronic directory in such a fashion that enables users of the Contractor’s website to search by:

###### Provider name;

###### Town;

###### ZIP code;

###### Provider specialty;

###### Provider languages spoken; and

###### Provider licensing information.

#### Within a reasonable time after EOHHS enrolls a new Enrollee, provide each such individual with notification that a copy of the Network Provider Directory can be accessed online at the Contractor’s website, and is available in writing upon request by calling the Member and Provider Services Department;

#### At EOHHS’s discretion, provide written notice to Enrollees of any changes in the Network Provider Directory at least 30 days before the intended effective date of the change or as soon as the Contractor becomes aware of such change;

#### In the event of the termination of a Network Provider, provide written notice within 15 days after receipt or issuance of the termination notice to each Enrollee who received his or her primary care from, was seen on a regular basis by, or was seen within the previous 90 days by, the terminated Provider, and ensure that care is transferred to another Network Provider in a timely manner to minimize any disruptions to treatment;

#### Provide annual notification to Providers, Enrollees and other interested parties that the most current version of the Network Provider Directory is available on the Contractor’s website and that hard copies are available on request.

### Non-Payment for Provider-Preventable Conditions

Pursuant to 42 CFR 438.3(g), the Contractor must:

#### Provide that no payment will be made by the Contractor to a Provider for a Provider Preventable Condition as defined in this Contract.

#### Require, as a condition of payment from the Contractor that all Providers in its Provider network comply with reporting requirements on Provider-Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by EOHHS.

#### Not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider’s initiation of treatment for that Enrollee.

#### A Contractor reduction in provider payment may be limited to the extent that the following apply:

##### The identified Provider-Preventable Condition would otherwise result in an increase in payment.

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

#### Ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

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## Enrollee Access to Services

### General

The Contractor:

#### Must demonstrate its ability to meet the needs of Enrollees competently and promptly;

#### Must offer adequate choice and availability of Providers, and allow each Enrollee to choose his or her Provider to the extent possible and appropriate;

#### Must provide adequate access to Covered Services (listed in Appendix A), including physical and geographic access. Such access must be designed to accommodate the needs of Enrollees who are disabled or non-English speaking, including access to TTY (for the deaf and hard of hearing) and translation services;

#### Must provide all Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided under MassHealth fee for service.

#### Must provide all Covered Services that are medically necessary pursuant to 130 CMR 450.204, including those Covered Services that:

##### Prevent, diagnose, and treat health impairments;

##### Achieve age-appropriate growth and development;

##### Attain, maintain, or regain functional capacity; and

##### Provide an opportunity for an Enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or choice.

#### Must ensure that all Covered Services are sufficient in an amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

#### May place appropriate limits on a Covered Service for the purpose of utilization control, provided that:

##### The furnished services can reasonably be expected to achieve their purpose;

##### Services supporting Enrollees with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the Enrollee’s ongoing need for such services and supports; and

##### Family planning services are provided in a manner that protects and enables the Enrollee’s freedom to choose the method of family planning to be used.

#### May place appropriate limits on a Covered Service on the basis of Medical Necessity. The Contractor’s Medical Necessity guidelines must, at a minimum, be:

##### Developed with input from practicing physicians throughout the Contractor’s Regions;

##### Developed in accordance with standards adopted by national accreditation organizations where applicable and available;

##### Developed in accordance with the definition of Medical Necessity in this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines;

##### Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

##### Evidence-based, if practicable; and

##### Applied in a manner that considers the individual health care needs of the Enrollee.

#### Must submit changes to its Medical Necessity guidelines, program specifications and services components for all Covered Services to EOHHS no less than 60 days prior to any change, or another timeframe specified by EOHHS;

#### Must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee;

#### Must comply with all federal requirements regarding the provision of services, including but not limited to 42 CFR 431.51(b)(2) and 42 CFR 441.202;

#### Must make interpretation services, including oral interpretation, and auxiliary aids and services, such as TTY/TDY and American Sign Language (ASL), available upon request of each Enrollee or Potential Enrollee at no cost; and

#### Must ensure that access to Covered Services for Enrollees is consistent with the degree of urgency, as follows:

##### Emergency Services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified Provider, whether a Network Provider or a non-Network Provider.

##### ESP Services shall be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including Enrollees, uninsured individuals and persons covered by Medicare only.

##### Urgent Care Services shall be provided within 48 hours.

##### Unless otherwise specified in this contract, all other care shall be provided in accordance with usual and customary community standards, and in all cases within 14 calendar days.

##### In accordance with 42 CFR 438.206(c)(1)(iii), the Contractor shall make Covered Services available 24 hours a day, seven days a week when medically necessary.

#### Must ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to individuals with commercial insurance, or comparable to Medicaid Fee-for-Service if the Network Provider serves only MassHealth Members;

#### Must ensure that, in the event the Contractor’s Provider Network is unable to provide necessary services covered under this Contract to a particular Enrollee, the Contractor will adequately and timely cover the services out of network, for as long as the Contractor’s Provider Network is unable to provide such services.

### Proximity Requirements

Each Enrollee must have a choice of at least two PCPs and two outpatient behavioral health Providers that are either within a 15-mile radius or 30 minutes from the Enrollee’s zip code of residence in the Enrollee’s Service Area.

### Availability of Services

#### 24-Hour Coverage

##### The Contractor must provide a single, toll-free telephone line, available to each and every Enrollee, with 24-hours-per-day, 7-days-per-week access to an on-call skilled health-care professional who:

###### Has immediate access to the CER (see Section 2.4.A.9);

###### Is able to address the Enrollee's medical and social needs;

###### Has the experience and knowledge to provide clinical triage; and

###### Is able to provide options other than waiting until business hours or going to the emergency room.

##### The Contractor must follow federal and State regulations about 24-hour service availability (for example, hospital, home health, and hospice require 24-hour availability; adult day health, homemaker, and chore services do not).

#### Triage System

The Contractor must maintain a triage system for the management of Emergency Conditions and Urgent Care. The triage system, including the identification of the appropriate level of care, must be driven by clinically based criteria consistent with clinical research and industry standards. The clinical criteria must include protocols about the processes for access to, and communication with, appropriate PCPs or PCTs and the Enrollee’s other Providers.

#### Access to Services for Emergency Conditions and Urgent Care

The Contractor must ensure access to 24-hour emergency services for all Enrollees, whether they reside in institutions or in the community.

##### When service for an Emergency Condition is required, the Contractor must have a process established to notify the PCP or PCT (or the designated covering physician) within one business day after the Contractor is notified by the Provider. If the Contractor is not notified by the Provider within 10 calendar days of the Enrollee’s presentation for emergency services, the Contractor is not responsible for payments;

##### When Urgent Care is required, the Contractor must have a process to notify the PCP or PCT within 24 hours after the Contractor is notified;

##### Summary information about Emergency Conditions and Urgent Care services provided must be recorded in the CER no more than 18 hours after the PCP or PCT is notified, and a full report of the services provided within two business days;

##### The Contractor shall cover and pay for Emergency Services in accordance with 42 CFR 438.114 and M.G.L. c. 118E, section 17A.

##### Pursuant to 42 U.S.C. §1396u-2(b)(2) and 42 CFR 438.114, the Contractor must cover and pay for Emergency Services rendered to an Enrollee, 24-hours a day and seven days a week, regardless of prior authorization or such provider’s contractual relationship with the Contractor. The Contractor shall pay a non-contracted provider of Emergency Services an amount equal to or, if the Contractor can negotiate a lower payment, less than the amount allowed under the state’s Fee-For Service rates, less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider’s charges.

##### The Contractor shall not:

###### Deny payment for treatment of an Emergency Medical Condition;

###### Deny payment for treatment when a representative of the Contractor instructed the Enrollee to seek Emergency Services. Treatment obtained when an Enrollee had an emergency medical condition;

###### Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms;

###### Hold an Enrollee who has an Emergency Medical Condition liable for subsequent screening and treatment needed to diagnose or stabilize the specific condition.

##### The Contractor shall require providers to notify the Enrollee’s Primary Care Provider of an Enrollee’s screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

##### An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

##### The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor if such transfer or discharge order is consistent with generally accepted principles of professional medical practice.

In Massachusetts, generally accepted principles of professional medical practice for behavioral health treatment require the provider of Emergency Services to obtain for the Enrollee an ESP service to receive crisis assessment, intervention and stabilization treatment to determine the need for appropriate Post-Stabilization Care Services, including Inpatient, Diversionary and Outpatient Services.

#### Urgent Care and Symptomatic Office Visits

All Urgent Care and symptomatic office visits must be available to Enrollees within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention. Examples include recurrent headaches or fatigue.

#### Nonsymptomatic Office Visits

All nonsymptomatic office visits must be available to Enrollees within 30 calendar days. Examples of nonsymptomatic office visits include, but are not limited to well and preventive-care visits for Covered Services, such as annual physical examinations or immunizations. (See **Appendix A** for a list of Covered Services.)

#### Choice of Long Term Care and Hospital Providers

The Contractor’s Provider Network must offer Enrollees access to at least two nursing facilities and two community long term care service Providers. When feasible, the Contractor’s Provider Network must also offer Enrollees access to at least two hospitals.

### Cultural and Linguistic Competence

The Contractor shall ensure that:

#### Multilingual Providers and, to the extent that such capacity exists within the Contractor’s Service Area, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations;

#### Network Providers and interpreters/transliterators are available for those who are deaf or hearing-impaired, to the extent that such capacity exists within the Contractor’s Service Area;

#### Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under the Contract; and

#### It identifies opportunities to improve the availability of fluent staff or skilled translation services in Enrollees’ preferred languages and opportunities to improve the cultural appropriateness of Enrollees’ care.

### Access for Enrollees with Disabilities

Physical and telephone access to services must be made available for individuals with disabilities. The Contractor must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the Contractor.

### Access to Home- and Community-Based Services

The Contractor must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence when office visits are unsafe or inappropriate for the Enrollee's clinical status. Service sites must include, but not be limited to, the Enrollee's private residence, or a nursing or assisted-living facility.

### Formulary

#### The Contractor shall make available, in electronic and paper form, the following information about its formulary:

##### Which medications are covered (both generic and name brand);

##### What tier each medication is on, if applicable; and

##### Any additional information required by EOHHS and/or CMS.

#### The Contractor shall maintain the formulary required by this section in both electronic and paper form as follows:

##### Electronic Version – The Contractor shall maintain the electronic version of its formulary on its website in a machine readable file and format.

##### Paper Version – Upon request, the Contractor shall provide each Enrollee or Potential Enrollee a paper version of its formulary.

#### If directed by EOHHS and/or CMS, the Contractor shall report the information required in this Section 2.6.G using a template provided by EOHHS or CMS.

## Enrollee Services

### Enrollee Service Representatives (ESRs)

The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees. ESRs must be capable of speaking directly with, or arranging for someone else to speak with, Enrollees in their primary language, or through an alternative language device or telephone translation service.

### ESR Support Functions

ESRs must:

#### Be knowledgeable about MassHealth, Medicare, and all terms of the Contract, including the Covered Services listed in Appendix A;

#### Be available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances; and

### Enrollee Service Telephone Responsiveness

ESRs must be available during normal business hours on a daily basis. The Contractor must answer 90% of all Enrollee telephone calls within 20 seconds, and be able to provide reports indicating compliance with this requirement upon request of EOHHS. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question.

## Enrollee Grievances and Appeals

The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeal Representatives, and the receipt, timely resolution, and documentation by the Contractor, of any and all Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this section, in cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent himself or herself, without parental/guardian consent.)

### General Requirements

#### The Contractor shall maintain written policies and procedures for the receipt and timely resolution of Grievances and Internal Appeals. Such policies and procedures shall be approved by EOHHS.

#### The Contractor shall review the Grievance and Internal Appeals policies and procedures established pursuant to subsection 1, above, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS.

#### The Contractor shall create and maintain records of Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity, using the health information system(s) specified in Section 2.14.B, to document:

##### The type and nature of each Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, and review by the CMS Independent Review Entity;

##### How the Contractor disposed of or resolved each Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, or review by the CMS Independent Review Entity; and

##### What, if any, corrective action the Contractor took.

#### The Contractor shall Report to EOHHS regarding Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity, as described in Appendix D and as follows in a form and format specified by EOHHS:

##### Annually report a summary;

##### Monthly report

###### Number of Appeals per 1,000 Enrollees;

###### Number of Grievances per 1,000 Enrollees.

#### The Contractor shall ensure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal or review by the CMS Independent Review Entity.

#### The Contractor shall put in place a standardized process that includes:

##### A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

##### A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in Sections 2.8.B.3 and 2.8.D, below; and

##### A means for expedited resolution of Internal Appeals, as further specified in Section 2.8.D.4, when the Contractor determines (for a request from the Enrollee) or a Provider indicates (in making the request on the Enrollee’s behalf or supporting the Enrollee’s request) that taking the time for a standard resolution, in accordance with Section 2.8.D.1.a, could seriously jeopardize the Enrollee’s life, health, or ability to attain, maintain, or regain maximum function.

#### The Contractor shall put in a place a mechanism to:

##### Accept Grievances filed either orally or in writing; and

##### Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action, provided that if an Internal Appeal is filed orally, the Contractor must require the Enrollee or Appeal Representative to submit a written, signed Internal Appeal form following the oral filing unless an expedited resolution is requested as specified in Section 2.8.D.4. Internal Appeals filed later than 60 calendar days from the notice of Adverse Action may be rejected as untimely.

#### The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Enrollees and, if an Appeal Representative filed the Grievance or Internal Appeal, to the Appeal Representative and the Enrollee within one business day of receipt by the Contractor.

#### The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in Section 2.8.B.

### Notice of Adverse Action

The Contractor shall put in place a mechanism for providing written notice to Enrollees of any Adverse Action in a form approved by EOHHS as follows:

#### The notice must meet the language and format requirements specified in Section 2.10.B.

#### The notice must explain the following:

##### The Adverse Action the Contractor has taken or intends to take;

##### The reason(s) for the Adverse Action, including the right of the Enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Action, such as medical necessity criteria and processes, strategies, and standards related to the Adverse Action;

##### The Enrollee’s right to file an Internal Appeal or to designate an Appeal Representative to file an Internal Appeal on behalf of the Enrollee, including exhausting the appeal process and right to file an appeal with the Board of Hearings;

##### The procedures for a Enrollee to exercise his/her right to file an Internal Appeal;

##### The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

##### That the Contractor will provide the Enrollee Continuing Services, if applicable, pending resolution of the review of an Internal Appeal if the Enrollee submits the request for review within 10 days of the Adverse Action;

##### That the Contractor will provide the Enrollee Continuing Services, if applicable, pending resolution of a BOH Appeal if the Enrollee submits the request for the BOH Appeal within 10 days of receipt of notice of the Internal Appeal decision, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services;

##### If the service decision regards a hospital discharge of an Enrollee covered by Medicare, the notice must explain the Quality Improvement Organization (QIO) Appeal process, which is outlined in Section 2.8.D.

#### The notice must be mailed within the following timeframes:

##### For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to five calendar days before the Date of Action if the Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee and the facts have been verified, if possible through secondary sources.

##### For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is not at issue, which include, but are not limited to, denials for the following reasons:

###### Failure to follow prior authorization procedures;

###### Failure to follow referral rules; and

###### Failure to file a timely claim.

##### For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in Section 2.4.A.14.c, as expeditiously as the Enrollee’s health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

###### The extension shall only be allowed if:

The Provider, Enrollee or Appeal Representative requests the extension, or

The Contractor can justify (to EOHHS, upon request) that:

The extension is in the Enrollee’s interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

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

###### If the Contractor extends the timeframe, it must:

Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

Issue and carry out its determination as expeditiously as the Enrollee’s health condition requires and no later than the date the extension expires.

##### For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in Section 2.4.A.14.d, as expeditiously as the Enrollee’s health requires but no later than 72 hours after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

###### The extension shall only be allowed if:

The Provider, Enrollee or Appeal Representative requests the extension, or

The Contractor can justify (to EOHHS, upon request):

The extension is in the Enrollee’s interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

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

###### If the Contractor extends the timeframe, it must do the following:

Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

Issue and carry out its determination as expeditiously as the Enrollee’s health condition requires and no later than the date the extension expires.

###### For standard or expedited service authorization decisions not reached within the timeframes specified in Section 2.14.A.15, whichever is applicable, on the day that such timeframes expire.

###### When the Contractor fails to provide services in a timely manner in accordance with the access standards in Sections 2.5.A and 2.6, within one business day upon notification by the Enrollee or Provider that one of the access standards in Sections 2.5.A and 2.6 was not met.

### Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

#### Inform Enrollees of the Grievance, Internal Appeal, and BOH Appeal procedures.

#### Give reasonable assistance to Enrollees in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TTD and interpreter capability;

#### Provide notice of Adverse Actions as specified in Section 2.8.B;

#### Accept Grievances and Internal Appeals filed in accordance with Section 2.8.A.7;

#### Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Enrollee and Appeal Representative within one business day of receipt by the Contractor;

#### Ensure that the individuals who make decisions on Grievances and Internal Appeals:

##### Are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

##### Take into account all comments, documents, records, and other information submitted by the Enrollee or the Appeal Representative without regard to whether such information was submitted or considered in the Adverse Action determination.

#### Ensure that the decision-makers on Grievances and Internal Appeals concerning any of the following are individuals who have the appropriate clinical expertise in treating the Enrollee’s medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance or Internal Appeal:

##### An Internal Appeal of a denial that is based on lack of Medical Necessity;

##### A Grievance regarding denial of expedited resolution of an Internal Appeal; and

##### A Grievance or Internal Appeal that involves clinical issues;

#### Ensure that the following special requirements are applied to Internal Appeals:

##### The Contractor shall offer one level of review of an Adverse Action for Internal Appeals;

##### All reviews of Internal Appeals shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

##### The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and may require the Enrollee or an Appeal Representative to confirm such oral requests in writing as specified in Section 2.8.A.7.b;

##### The Contractor shall provide a reasonable opportunity for the Enrollee or an Appeal Representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Enrollee or an Appeal Representative about the limited time available for this opportunity in the case of an expedited Internal Appeal;

##### The Contractor shall provide the Enrollee and Appeal Representative, before and during the Internal Appeal process, the Enrollee’s case file, including medical records, and any other documentation and records considered, relied upon, or generated during the Internal Appeal process. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe; and

##### The Contractor shall include, as parties to the Internal Appeal, the Enrollee and Appeal Representative or the legal representative of a deceased Enrollee’s estate.

### Resolution and Notification of Grievances and Internal Appeals

The Contractor shall:

#### Dispose of each Grievance, resolve each Internal Appeal, and provide notice of each disposition and resolution, as expeditiously as the Enrollee’s health condition requires, within the following timeframes:

##### For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Enrollee or the Enrollee’s authorized Appeal Representative;

##### For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received, either in writing or orally, whichever comes first, the Enrollee request’s for an Internal Appeal, unless this timeframe is extended under Section 2.8.D.2.b, below;

##### For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours after the Contractor received the expedited Internal Appeal unless this timeframe is extended under Section 2.8.D.2.b, below. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Enrollee’s Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form. The Contractor must require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Enrollee did in fact authorize the Provider to file the expedited Internal Appeal on the Enrollee’s behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

#### Extend the timeframes specified in Section 2.8.D.1 as follows:

##### Extend the timeframe in Section 2.8.D.1.a by up to 14 calendar days if:

###### The Enrollee or Appeal Representative requests the extension, or

###### The Contractor can justify (to EOHHS upon request) that:

The extension is in the Enrollee’s interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

Such outstanding information is reasonably expected to be received within five calendar days;

##### Extend the timeframes in Section 2.8.D.1.b and Section 2.8.D.1.c for up to 14 calendar days if:

###### The Enrollee or Appeal Representative requests the extension, or

###### The Contractor can justify (to EOHHS upon request) that:

The extension is in the Enrollee’s interest; and

There is a need for additional information where:

There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

Such outstanding information is reasonably expected to be received within 14 calendar days;

##### For any extension not requested by the Enrollee, the Contractor shall:

###### Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the delay;

###### Provide the Enrollee and Appeal Representative written notice of the reason for the delay within 2 calendar days. Such notice shall include the reason for the extension and the Enrollee’s right to file a grievance; and

###### Resolve the appeal as expeditiously as the Enrollee’s health condition requires and no later than the date the extension expires.

#### Provide notice in accordance with Section 2.8.D.1, above, regarding the disposition of a Grievance or the resolution of a standard or expedited Internal Appeal as follows:

##### All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notice of an expedited Internal Appeal resolution, the Contractor must also make reasonable efforts to provide oral notice to the Enrollee; and

##### The notice shall contain, at a minimum, the following:

###### The results of the resolution process and the effective date of the Internal Appeal decision;

###### For Internal Appeals not resolved wholly in favor of the Enrollee:

The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing form; and

That the Enrollee will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Enrollee submits the appeal request to the BOH within 10 days of the Adverse Action, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services.

#### Resolve expedited Internal Appeals as follows:

##### The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in Section 2.8.D.1.c, above, when the Contractor determines (with respect to a Enrollee’s request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Enrollee’s behalf or supporting the Enrollee’s request) that taking the time for a standard resolution could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving as the Enrollee’s Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

##### The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support a Enrollee’s Internal Appeal.

##### If the Contractor denies a Enrollee’s request for an expedited resolution of an Internal Appeal, the Contractor shall:

###### Transfer the Internal Appeal to the timeframe for standard resolution in Section 2.8.D.1, above; and

###### Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the denial, and follow up within two calendar days with a written notice. Such notice shall include the Enrollee’s right to file a Grievance.

###### Resolve the appeal as expeditiously as the Enrollee’s health condition requires, and no later than the applicable deadlines set forth in this Contract.

##### The Contractor shall not deny a Provider’s request (on a Enrollee’s behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider’s request is unrelated to the Enrollee’s health condition.

### Ombudsman Coordination

The Contractor shall support Enrollee access to, and work with, the Ombudsman, once available, to address Enrollee and Eligible Beneficiary requests for information, issues, or concerns related to SCO, including:

#### Educating Enrollees about the availability of Ombudsman services:

##### At orientation;

##### When members receive the Enrollee Handbook package;

##### At the time of the Ongoing Assessments; and

##### When Enrollees – or their family members or representatives – contact the Contractor, including ESR and provider staff, with a concern, Complaint, grievance or Appeal;

#### Communicating and cooperating with Ombudsman staff as needed for them to investigate and resolve Enrollee or Eligible Beneficiary requests for information, issues, or concerns related to SCO, including:

##### Providing Ombudsman staff with access to records needed to investigate and resolve Enrollee Complaints (with the Enrollee’s approval); and

##### Ensuring ongoing communication and cooperation of Plan staff with Ombudsman staff in working to investigate and resolve Enrollee complaints, including updates on progress made towards resolution, until such time as the complaints have been resolved.

### CMS Independent Review Entity

#### If on internal Appeal the Contractor does not decide fully in the Enrollee’s favor and the Appeal is regarding a Medicare covered service, within the relevant time frame, the Contractor will automatically forward the case file to the CMS Independent Review Entity for a new and impartial review. The CMS Independent Review Entity is contracted by CMS.

#### For standard external Appeals, the CMS Independent Review Entity will send the Enrollee and the Contractor a letter with its decision within 30 calendar days after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

#### If the CMS Independent Review Entity decides in the Enrollee’s favor and reverses the Contractor’s decision, the Contractor must authorize the service under dispute within 72 hours from the date the Contractor receives the review entity’s notice reversing the Contractor’s decision, or provide the service under dispute as expeditiously as the Enrollee’s health condition requires, but no later than 14 calendar days from the date of the notice.

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

##### If the CMS Independent Review Entity decides in the Enrollee’s favor, the Contractor must authorize or provide the service under dispute as expeditiously as the Enrollee’s health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision. If the CMS Independent Review Entity reverses an Action to deny, limit, or delay services, and the Enrollee received such services while the appeal was pending, the Contractor shall pay for such services.

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

### BOH Appeals

If, on internal Appeal, the Contractor does not decide fully in the Enrollees’ favor, and the Appeal concerns a Medicaid covered service, the Contractor shall:

#### Require Enrollees and their Appeal Representatives to exhaust the Contractor’s Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

##### The Contractor has issued a decision following its review of the Adverse Action; or

##### The Contractor fails to act within the timeframes for reviewing Internal Appeals or fails to satisfy applicable notice requirements;

#### Include with any notice following the resolution of an Internal Appeal any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Enrollee to request a BOH Appeal; and

#### Notify Enrollees that:

##### Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services and that the Enrollee may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Enrollee; and

##### It is the Enrollee’s or the Appeal Representative’s responsibility to submit any request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the following time limits, as specified in 130 CMR 610.015(B)(7):

###### For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in Section 2.8.D.1.b, 30 calendar days after the notice following the Internal Appeal, as specified in Section 2.8.D.3;

###### For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in Section 2.8.D.1.b, in which the Enrollee wants to continue receiving the services that are the subject of the BOH Appeal, 10 calendar days after the notice following the Internal Appeal, as specified in Section 2.8.D.3;

###### For BOH Appeals of an expedited Internal Appeal resolved by the Contractor within the timeframe specified in Section 2.8.D.1.c, 20 calendar days after the notice following the Internal Appeal, as specified in Section 2.8.D.3, or within 30 calendar days in which case the BOH Appeal will be treated as a non-expedited (i.e., standard) BOH Appeal request;

###### For BOH Appeals of a standard Internal Appeal not resolved by the Contractor within the timeframe specified in Section 2.8.D.1.b, 30 calendar days from the date on which that timeframe expired; and

###### For BOH Appeals of an expedited Internal Appeal not resolved by the Contractor within the timeframe specified in Section 2.8.D.1.c, 20 calendar days from the date on which that timeframe expired.

#### Be a party to the BOH Appeal, along with the Enrollee and his or her representative or the representative of a deceased Enrollee’s estate.

### Hospital Discharge Appeals

#### When a Dual Eligible Senior Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation called Important Notice from Medicare About Your Rights (IM).

#### The Enrollee has the right to request a review by a QIO of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.

#### If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.

#### The QIO will make its decision within one full working day after it receives the Enrollee’s request, medical records, and any other information it needs to make its decision.

#### If the QIO agrees with the Contractor’s decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar following the day the QIO notifies the Enrollee of its decision.

#### If the QIO overturns the Contractor’s decision, the Contractor must pay for the remainder of the hospital stay.

### Continuing Services

#### The Contractor shall comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

#### The Contractor shall provide Continuing Services until one of the following occurs:

##### The Enrollee withdraws the Internal Appeal or BOH Appeal;

##### The Enrollee does not request a BOH Appeal in a timely fashion after the Contractor sends the notice of an adverse Internal Appeal resolution; or

##### The BOH issues a decision adverse to the Enrollee.

#### If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee’s health condition requires, but no later than 72 hours from the date it receives notice reversing the determination; and

#### If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Enrollee received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.

### Additional Requirements

The Contractor shall:

#### For all Internal Appeal decisions upholding an Adverse Action, in whole or in part, the provide EOHHS, within one business day of issuing the decision, with a copy of the decision sent to the Enrollee and Appeal Representative, as well as all other materials associated with such Appeal, to assist in EOHHS’s review of the Contractor’s determination. This requirement shall also apply to situations when the Contractor fails to act within the timeframes for reviewing Internal Appeals;

#### Upon learning of a hearing scheduled on a BOH Appeal concerning such a Internal Appeal, notify EOHHS immediately and include the names of the Contractor’s clinical and other staff who will be attending the BOH hearing;

#### Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS’s interpretation of any statute, regulation, and contractual provisions that relates to the decision;

#### Submit all applicable documentation to the BOH, EOHHS, the Enrollee and the designated Appeal Representative, if any, within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;

#### Make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Enrollee, and the Contractor within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing;

#### Comply with and implement the decisions of the BOH;

#### In the event that the Enrollee appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and

#### Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

##### Determine whether each Enrollee who requests a BOH Appeal has exhausted the Contractor’s Internal Appeals process, in accordance with Sections 2.8.C and 2.8.D;

##### If requested by the Enrollee, assist the Enrollee with completing a request for a BOH Appeal;

##### Receive notice from the BOH that an Enrollee has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;

##### Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Service;

##### Instruct Enrollees for whom an Adjustment has been made about the process of informing the BOH in writing of all Adjustments and, upon request, assist the Enrollee with this requirement, as needed;

##### Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

##### Ensure that appropriate Contractor staff attend BOH hearings;

##### Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

##### Upon notification by BOH of a decision, notify EOHHS immediately;

##### Ensure that the Contractor implements BOH decisions upon receipt;

##### Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

##### Coordinate with the BOH, as directed by EOHHS; and

##### Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

#### Provide information about the Contractor’s grievances and appeals policies to all Providers and Subcontractors at the time the Contractor and these entities enter into a contract; and

#### Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:

##### A general description of the reason for the Appeal or Grievance;

##### The date received, the date of each review, and, if applicable, the date of each review meeting;

##### Resolution of the Appeal or Grievance, and date of resolution; and

##### Name of the Enrollee for whom the Appeal or Grievance was filed.

## Quality Management

In accordance with federal and State requirements, including 42 CFR 438.330, the Contractor must operate an ongoing quality management program, which includes quality assessment and performance improvement, for the services that it furnishes to its Enrollees. The Contractor must also participate in annual external quality reviews conducted by the External Quality Review Organization.

### Quality Management (QM) and Quality Improvement (QI) Principles

The Contractor shall:

#### Deliver quality care that enables Enrollees to stay healthy, get better and, if necessary, manage a chronic illness or disability. Quality care refers to:

##### Clinical quality of physical health care;

##### Clinical quality of behavioral health care focusing on recovery, resiliency and rehabilitation;

##### Effectiveness of long term services and supports in delivering person-centered services designed to maintain and restore function and avoid clinical and functional decline;

##### Access and availability of primary and specialty health care Providers and services;

##### Continuity and coordination of care across settings, and transitions in care; and

##### Enrollee experience with respect to clinical quality, access and availability and Cultural and Linguistic Competence of health care and services, and continuity and coordination of care;

#### Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor’s service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

##### Quantitative and qualitative data collection and data-driven decision-making;

##### Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

##### Feedback provided by Enrollees and Providers in the design, planning, and implementation of its CQI activities; and

##### Issues identified by the Contractor or EOHHS.

#### Ensure that the QM/QI requirements of this Contract are applied to the delivery of both Physical Health Services and Behavioral Health Services.

### QM/QI Program Structure

The Contractor shall maintain a well-defined QM/QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor’s service delivery system. The QM/QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor’s QM/QI organizational and program structure shall comply with all applicable provisions of 42 CFR Part 438, including Subpart E, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall:

#### Ensure that the QM/QI program is informed by consistent utilization and analysis of data, incorporating at least the following elements:

##### A process for collecting, analyzing and managing with data to improve Enrollees’ health outcomes, functional status, and well-being;

##### A process for collecting and submitting performance measurement data in accordance with 42 CFR 438.330;

##### A process for tracking to resolution areas targeted for QI as identified by the Contractor, EOHHS or CMS;

##### Using multiple data sources and drawing conclusions based on data to drive system improvement through evidence-based practices, practice guidelines, and other data-driven clinical initiatives.

#### Establish a set of QM/QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QM/QI initiatives and for the completion of QM/QI initiatives in a competent and timely manner;

#### Ensure that such QM/QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor’s service delivery system;

#### Include mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs;

#### Include mechanisms to assess the quality and appropriateness of care furnished to Enrollees using long-term services and supports, including:

##### An assessment of care between care settings;

##### A comparison of services and supports received with those set forth in the Enrollee’s treatment plan; and

##### Alignment of the assessment, care plan and individual person-centered goals.

#### Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare) that are based on, at a minimum, the requirements for the State’s home- and community-based waiver programs;

#### Establish internal processes to ensure that the QM activities for Physical and Behavioral Health Services reflect utilization across the Network and include all of the activities in this Section 2.9 of this Contract and, in addition, the following elements:

##### A process to utilize HEDIS results in designing QM/QI activities;

##### A medical record review process for monitoring Network Provider compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to EOHHS;

##### A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor’s Plan. The Contractor shall submit a survey plan to EOHHS for approval and shall submit the results of the survey to EOHHS;

##### A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

##### A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in Enrollee and family advisory councils;

##### In collaboration with and as further directed by EOHHS, a plan to monitor Intensive Care Coordination and Family Training and Support Services according to fidelity measures that are consistent with national Wraparound standards;

#### Have in place a written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor’s QM/QI initiatives. Such description shall:

##### Address all aspects of health care, including specific reference to behavioral health care, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health aspects of the QM/QI program may be included in the QM/QI description, or in a separate QM/QI Plan referenced in the QM/QI description;

##### Address the roles of the designated physician(s) and behavioral health clinician(s) with respect to QM/QI program;

##### Identify the resources dedicated to the QM/QI program, including staff, or data sources, and analytic programs or IT systems; and

##### Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management;

#### Submit to EOHHS an annual QM/QI Work Plan, in accordance with Appendix L, that shall include the following components or other components as directed by EOHHS:

##### Planned clinical and non-clinical initiatives;

##### The objectives for planned clinical and non-clinical initiatives;

##### The short and long term time frames within which each clinical and non-clinical initiative’s objectives are to be achieved;

##### The individual(s) responsible for each clinical and non-clinical initiative;

##### Any issues identified by the Contractor, EOHHS, Enrollees, and Providers, and how those issues are tracked and resolved over time; and

##### The evaluations of clinical and non-clinical initiatives, including Provider profiling activities as described in Section 2.5.c.1.b and the results of Network Provider satisfaction surveys as described in Section 2.9.B.7.c. above;

#### Evaluate the results QM/QI initiatives at least annually, and submit the results of the evaluation to the EOHHS QM manager. The evaluation of the QM/QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor’s assessment of the clinical quality of physical and behavioral health care rendered, and accomplishments and compliance and/or deficiencies in meeting the previous year’s QM/QI Strategic Work Plan.

### QM/QI Activities

#### Annual Performance Improvement Projects

##### The Contractor must annually develop at least two specific Performance Improvement Projects in the areas of integration of Primary Care, long term care, and behavioral health or areas that involve the implementation of interventions to achieve improvement in the access to and quality of care. The Contractor must provide documentation on each project, describing:

###### The problem to be addressed by the project;

###### The rationale;

###### How performance will be measured, using objective quality indicators;

###### The target population;

###### The method of evaluating performance;

###### How findings will be documented;

###### How recommendations will be developed and implemented; and

###### An evaluation of the effectiveness of the interventions based on the performance measures collected as part of the Performance Improvement Project.

#### Quality Management Resources

The Contractor must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. The following must be available:

##### Quality Management Director

An identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Geriatric Model of Care.

##### Medical Director

A medical director licensed by the Massachusetts Board of Registration in Medicine with geriatric expertise and experience in community and institutional long term care, who will be responsible for establishing medical protocols and practice guidelines to support the program initiatives in **Section 2.9.C.3** below.

##### Geriatrician

A qualified geriatrician, licensed by the Massachusetts Board of Registration in Medicine and further certified in Geriatric Medicine, who will be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support a geriatric model of practice. The medical director may also serve as the Geriatrician if they meet the requirements.

##### Behavioral Health Clinician

A qualified behavioral health clinician, with expertise in geriatric service, who will be responsible for establishing behavioral health protocols and providing specialized support to PCPs and PCTs.

#### Program Initiatives

##### Initiative to Reduce Preventable Hospital Admissions

The Contractor must have and comply with written protocols to minimize unnecessary or inappropriate hospital admissions and a reporting system to record all preventable hospital admissions. The protocols must include at least the following:

###### Monitoring and risk-assessment mechanisms, which are operative on a continuous basis, to identify Enrollees at-risk of hospitalization for at least the following conditions or profiles: pneumonia, dehydration, injuries from falls, skin breakdown, loss of informal caregiver, and history of noncompliance with treatment programs;

###### Processes that link the Initial and Ongoing Assessments to the timely provision of appropriate preventive care and other treatment interventions to at-risk Enrollees. Such processes must emphasize continuity of care and coordination of services and must be in accordance with accepted clinical practice. The Contractor must perform outcome analyses to evaluate the effectiveness of the protocols; and

###### Formal linkages among the PCP, PCT, and Providers (specialty, long term care, and behavioral health) through the CER and other mechanisms, that must be used to provide timely information to the Contractor’s Provider Network, in order to implement early interventions for Enrollees and prevent hospitalizations.

##### Discharge Planning Initiative

The Contractor must have and comply with written protocols and a reporting system to record discharge activities to ensure that Enrollees who are admitted to an institution receive the following:

###### Interdisciplinary Discharge Planning and implementation processes that begin at the point of admission to the hospital or nursing facility;

###### Involvement of the Enrollee, and if applicable, the GSSC, the Providers of home- and community-based services, and the Enrollee’s designated representative, in determining which discharge setting is appropriate; and

###### Care planning and arranging for services and equipment that will be needed upon discharge.

##### Preventive Immunization(s)

The Contractor must have and comply with written protocols to provide pneumococcal vaccine and timely annual influenza immunizations and other relevant vaccines, as recommended by the Centers for Disease Control (CDC), and a reporting system to record all immunizations given. The protocols must include the following components:

###### Development and distribution of Contractor and PCP/PCT practice guidelines and measurement of PCP/PCT compliance with the guidelines;

###### Educational Outreach to Enrollees and caregivers about appropriate preventive immunization schedules; and

###### Prompt access to immunizations for ambulatory, homebound, and institutionalized Enrollees.

##### Screening for Early Identification of Cancer

The Contractor must have and comply with written protocols to provide cancer-screening services, and the provision of appropriate follow-up services. The Contractor must develop a reporting system to record all tests given, positive findings, and actions taken to provide appropriate follow-up care. The protocols must include the following components:

###### Written practice guidelines developed in accordance with accepted clinical practice, provided to all PCP/PCTs, with compliance measured at least annually;

###### Education Outreach to both Enrollees and caregivers about preventive cancer-screening services; and

###### Cancer screening recommendations as designated by the U.S. Preventative Task Force.

##### Disease Management

The Contractor must have and comply with written protocols to manage the care for Enrollees identified with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and depression and a reporting system that produces clinical indicator data as required in **Section 2.14.A.2**. The protocols must include the following:

###### Written practice guidelines, in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards;

###### Measurement and distribution of reports relating to Contractor and PCP/PCT compliance with practice guidelines;

###### Educational programming for Enrollees and caregivers that emphasizes self‑care and maximum independence;

###### Formal educational processes for clinical Providers in the best practices of managing the disease; and

###### Evaluation of effectiveness of each program by measuring outcomes of care.

##### Management of Dementia

The Contractor must have and comply with written protocols to identify dementia and its stage, manage the care for Enrollees identified with dementia and a reporting system that produces clinical indicator data. The protocols must include the following:

###### Written practice guidelines and trainings in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards, with evaluation of the effectiveness of these protocols on outcomes of care and management of disease progression;

###### Measurement and distribution of reports relating to compliance with practice guidelines;

###### Educational programming for significant caregivers that emphasizes community-based care and support systems for caregivers; and

###### Formal educational process for clinical Providers in the best practices of managing dementia.

##### Appropriate Nursing Facility Institutionalization

The Contractor must have and comply with written protocols for nursing facility admissions and report institutional utilization data. The protocols must include the following activities:

###### Identify medical conditions and patient profiles that differentiate between Enrollees at risk of being institutionalized and those who require institutional care;

###### Develop monitoring and risk-assessment mechanisms that assist the PCP or PCT to identify Enrollees at risk of institutionalization;

###### Implement processes that link Initial and Ongoing Assessments to the timely provision of appropriate preventive care and treatment interventions to at-risk Enrollees. Such protocols must emphasize continuity of care and coordination of services. The protocols must be based upon an evaluation of the outcomes and costs of care;

###### Implement processes to ensure the timely provision of nursing facility services when necessary;

###### Identify and formalize the linkages present between the PCPs, PCTs, and the long term care Providers of home- and community-based services, and how these linkages encourage and support maintaining Enrollees in their communities as long as appropriate; and

###### For individuals who can safely and adequately be cared for in the community, implement a Discharge Planning program that begins at the point of admission to any institution, to ensure the earliest appropriate discharge to community long term care.

##### Substance Abuse Prevention and Treatment Initiative

The Contractor must have and comply with written protocols to prevent, identify, and treat substance abuse and a reporting system that produces utilization data. Protocols must include the following:

###### Written practice guidelines, in accordance with accepted clinical guidelines, to treat substance abuse and evaluate the effectiveness of the treatment;

###### Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs;

###### Procedures for identifying Enrollees who are currently abusing substances including narcotics and alcohol or at risk for abuse; and

###### Documentation of coordination between the PCP or PCT and the behavioral health Provider.

##### Abuse and Neglect Identification Initiative

The Contractor is a mandated reporter of elder abuse under State law. The Contractor must submit to EOHHS Incident Reports that document all alleged incidents of abuse, neglect and exploitation of an Enrollee and all actions taken by the Contractor in response to those alleged incidents. In addition, the Contractor must have and comply with written protocols to prevent and treat abuse, neglect, and exploitation of Enrollees. Protocols must include the following:

###### Diagnostic tools, in accordance with accepted clinical practice, for identifying Enrollees who are experiencing, or who are at risk of, abuse and neglect;

###### Written practice guidelines to treat abuse and neglect of Enrollees and evaluate effectiveness of interventions;

###### Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs; and

###### Documentation of coordination between the PCP or PCT and protective service Providers.

#### Assessment of New Medical Technology

The Contractor must maintain policies and procedures to evaluate the use of new medical technologies or new applications of established technologies including medical procedures, drugs, and devices specifically appropriate and effective for the geriatric population. The criteria and evaluation methods used in this process must be based on scientific evidence. Enrollee rights must be protected in accordance with **Appendix B**.

#### Consumer Assessment of Healthcare Providers and Services (CAHPS)

The Contractor must conduct, as directed by EOHHS, an annual SCO-level (as opposed to Contractor-level) CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor and report CAHPS data to EOHHS annually on the anniversary of the start date of this Contract.

#### Ethics Committee

The Contractor must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including end-of-life issues and advance directives.

#### Electronic Visit Verification Initiative

The Contractor must cooperate with the EOHHS on development and future implementation of Electronic Visit Verification (EVV) and ensure that SCO EVV systems comply with the requirements outlined in Section 12006 of the 21st Century Cures Act (codified as 42 USC 1396b(I)) and as directed by EOHHS.

#### Serious Reportable Events

The Contractor shall cooperate with EOHHS in developing and implementing a process for ensuring non-payment for services constituting or resulting from so-called serious reportable events, as defined by the National Quality Forum.

#### Long-Term Services and Supports Advisory Committee

Pursuant to 42 CFR 438.110, the Contractor must establish and maintain a long-term services and supports member advisory committee. At a minimum, this committee must include a reasonably representative sample of the Enrollees receiving long-term services and supports under this Contract, or their representatives.

#### CMS-Specified Performance Measurement and Performance Improvement Projects

The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 CFR 438.330.

#### The Contractor will participate with EOHHS in the ongoing development and adoption of quality measures specifically related to delivery by the Contractor of long term services and supports.

#### According to the timeframes established in Appendix L, the Contractor must provide EOHHS with reports on progress toward reaching established Quality Management Goals.

## Outreach Standards

### General Outreach Requirements

The Contractor shall:

#### Submit to EOHHS an annual comprehensive Outreach plan on January 1 for the upcoming calendar year including proposed approaches to groups and individuals representing the cultural diversity of the Contractor’s Service Area;

#### Obtain EOHHS approval of the Outreach plan and materials, before conducting any Outreach activities or distributing such materials;

#### Ensure that Outreach materials accurately reflect the Contractor’s Provider Network and services offered and do not include false, misleading, or inaccurate information;

#### Refer Enrollees and Potential Enrollees who inquire about MassHealth eligibility or enrollment to EOHHS;

#### Make available to EOHHS and CMS, upon request, current schedules of all activities initiated or promoted by the Contractor to provide information or to encourage enrollment; and

#### Convene all promotional events at sites within the Contractor’s Service Area that are physically accessible to all Consumers (for example, to those in wheelchairs and those using public transportation).

### Requirements for Outreach and Enrollee Materials

The Contractor must:

#### Submit to EOHHS all forms of all Outreach and Enrollee materials, including non-English Outreach materials along with an English translation, an attestation from a certified translation agency, and a signature of the SCO Director, for review and approval before use or distribution. EOHHS must also approve any changes or updates to Outreach materials before use or distribution. Such materials include, but are not limited to:

##### Outreach and education materials;

##### Orientation materials;

##### Enrollment and disenrollment materials;

##### Benefit coverage information; and

##### Operational letters for enrollment, disenrollment, claims, service denials, Grievances, Appeals, and Provider terminations.

#### Ensure that all information provided to Enrollees and Potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood. At a minimum, all written materials must:

##### Be written in large print (at least 12 point), including any footnotes and subscript annotations;

##### Include a large print tagline (i.e., no smaller than 18 point font size);

##### Be translated in the Prevalent Languages used in the Service Area. If EOHHS notifies the Contractor that Prevalent Languages shall include additional languages, the Contractor shall submit a work plan to EOHHS within 60 days of the notice and shall comply with the work plan, as approved by EOHHS;

##### Be distributed throughout the entire Service Area;

##### Be produced in a manner, format, and language that may be easily understood and be readily accessible by Enrollees and Potential Enrollees with limited English proficiency or literacy;

##### Be Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor’s membership;

##### Be made available in Alternative Formats in an appropriate manner that takes into consideration the special needs of those Enrollees or Potential Enrollees who have disabilities or limited English proficiency at no cost. Such written materials must also include taglines in the Prevalent Languages used in the State, as well as large print, explaining how to request auxiliary aids and services, including materials in Alternative Formats;

##### Include a notice which explains that the enclosed materials are important and should be translated immediately, and provides information on how the Enrollee may obtain help with getting written translation or oral interpretation services at no cost. This notice shall:

###### Be written in large print in all Prevalent Languages, as well as Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian and Vietnamese, and other languages as directed by EOHHS;

###### Explain that oral interpretation services are available for any language at no cost, which notice shall explain how to access those services;

###### Written translation services are available for any Prevalent Language at no cost, which notice shall explain how to access those services;

#### Have in place mechanisms to help Enrollees and Potential Enrollees understand the requirements and benefits of the Contractor’s plan;

#### Not be provided electronically unless all of the following are met:

##### The format is readily accessible;

##### The information is placed in a location on the Contractor’s web site that is prominent and readily accessible;

##### The information is provided in an electronic form which can be electronically retained and printed;

##### The information is consistent with the content and language requirements of this Contract; and

##### The Enrollee is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days.

#### Ensure that all pre-enrollment and disenrollment materials include a statement that the Contractor’s plan is a voluntary MassHealth benefit in association with EOHHS and CMS;

#### Have the following information available upon the request of an Enrollee or Potential Enrollee:

##### A clear, comprehensive description of the Contractor’s plan including all enrollment requirements;

##### Detailed information about the Covered Services;

##### A description of the options Enrollees and Potential Enrollees have to enroll, disenroll, and transfer on a monthly basis;

##### A directory of all Providers in the Contractor’s Provider Network;

##### Information on the Enrollee’s right to file a Grievance or Appeal; and

#### Develop, using a model to be provided by EOHHS to the Contractor, an Enrollee handbook, which serves as a summary of benefits and coverage.

##### At a minimum, this handbook shall contain all of the information required by 42 CFR 438.10(g), including:

###### The benefits provided by the Contractor;

###### How to access Covered Services, including the amount, duration and scope of Covered Services, in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including the Contractor’s toll-free telephone line(s), authorization requirements, information regarding applicable access and availability standards, any cost sharing, self-referral, and referral by family members or guardians, a Provider, PCP, or community agency;

###### How to access non-Covered Services, including any cost sharing, if applicable, and how transportation to such services may be requested. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the handbook must inform Enrollees that the service is not covered by the Contractor and how they can obtain information from EOHHS about how to access those services;

###### The process of selecting and changing the Enrollee’s PCP;

###### The name and customer services telephone number for all Subcontractors that provide Covered Services to Enrollees unless the Contractor retains all customer service functions for such Covered Services;

###### The Covered Services that do not require authorization or a referral from the Enrollee’s PCP;

###### The extent to which, and how, Enrollees may obtain benefits, including Emergency Services and family planning services, from out-of-network providers;

###### The role of the PCP, and the policies on referrals for specialty care and for other benefits not furnished by the Enrollee’s PCP;

###### An explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider;

###### How to obtain information about Network Providers;

###### The extent to which, and how, after-hours and Emergency Services and Poststablization Care Services are covered, including:

What constitutes an Emergency Medical Condition, Emergency Services, and Poststabilization Care Services;

The fact that prior authorization is not required for Emergency Services;

How to access the Contractor’s 24-hour Clinical Advice and Support Line,

The process and procedures for obtaining Emergency Services, including the use of the 911-telephone system;

The services provided by Emergency Services Programs (ESPs) and how to access them;

The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services; and

The fact that the Enrollee has a right to use any hospital or other setting for Emergency Services;

###### Information regarding Enrollee cost sharing;

###### How to obtain care and coverage when outside of the Contractor’s Region;

###### Any restrictions on freedom of choice among Network Providers;

###### The availability of free oral interpretation services at the Plan in all non-English languages spoken by Enrollees and how to obtain such oral interpretation services;

###### The availability of all written materials that are produced by the Contractor for Enrollees in Prevalent Languages and how to obtain translated materials;

###### The availability of all written materials that are produced by the Contractor for Enrollees in Alternative Formats and how to access written materials in those formats and the availability of auxiliary aids and services;

###### The toll-free Enrollee services telephone number and hours of operation, the toll-free telephone number for medical management, and the toll-free telephone number for any other unit providing services directly to Enrollees;

###### The rights and responsibilities of Enrollees, including the Enrollee’s right to:

Receive information on beneficiary and plan information;

Be treated with respect and with due consideration for his or her dignity and privacy;

Receive information on available treatment and alternatives, presented in a manner appropriate to the Enrollee’s condition and ability to understand;

Participate in decisions regarding his or her health care, including the right to refuse treatment;

Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

Request and receive a copy of his or her medical records and request that such records be amended or corrected; and

Obtain available and accessible health care services covered under this Contract.

###### Information on Grievance, Internal Appeal, and Board of Hearing (BOH) procedures and timeframes, including:

The right to file Grievances and Internal Appeals;

The requirements and timeframes for filing a Grievance or Internal Appeal;

The availability of assistance in the filing process;

The toll-free numbers that the Enrollee can use to file a Grievance or an Internal Appeal by phone;

The fact that, when requested by the Enrollee, Covered Services will continue to be provided if Enrollee files an Internal Appeal or a request for a BOH hearing within the timeframes specified for filing, and that the Enrollee may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Enrollee;

The right to obtain a BOH hearing;

The method for obtaining a BOH hearing;

The rules that govern representation at the BOH hearing;

The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information; and

The availability of the ombudsman.

###### Information on advance directives in accordance with Section 5.5.E;

###### Information on the access standards specified in Section 2.5.A and 2.6;

###### Information on how to report suspected fraud or abuse; and

###### Any other information required by EOHHS.

##### The Contractor shall distribute this handbook to each Enrollee as follows:

###### For each existing Enrollee, the Contractor shall:

Mail a printed copy of the handbook to the Enrollee at his or her mailing address;

Provide an electronic copy of the handbook by electronic mail after obtaining the Enrollee’s agreement to receive the information by electronic mail;

Post the handbook on its website and advise the Enrollee, in both paper and electronic form, that the handbook is available on the internet, including the appropriate URL, provided that Enrollees with disabilities who cannot access the handbook online are provided auxiliary aids and services upon request at no cost; or

Provide the handbook by any other method that can reasonably be expected to result in the Enrollee receiving the information contained in the handbook.

###### For new Enrollees, the Contractor shall, within 10 days after receiving notice of the Member’s enrollment with the Contractor, or by the last day of the month prior to the effective date, whichever is later, distribute the handbook in accordance with Section 2.10.B.7.b.1.

#### Develop Enrollee notices using models to be provided by EOHHS to the Contractor.

#### Adopt definitions as specified by EOHHS, consistent with 42 CFR 438.10(c)(4)(i):

### Optional Outreach Activities

The Contractor may:

#### Post written Outreach and promotional materials approved by CMS and EOHHS at Contractor Provider Network sites and other sites throughout the Service Area of the Contractor;

#### Access television, radio, electronic media and printed media, including free newspapers, for the purpose of Outreach or promotion in accordance with the requirements set forth in this Contract. All text, scripts, and materials developed by the Contractor for this purpose require review and approval by CMS and EOHHS before use;

#### Distribute approved Outreach and promotional materials by mail to Potential Enrollees, provided that the Contractor distributes such materials throughout the Contractor’s entire Service Area;

#### Provide nonfinancial promotional items only if they are offered to everyone who attends the event, regardless of whether or not they enroll with the Contractor, and only if the items are of a retail value of $15.00 or less; and

#### Conduct nursing facility visits and home visits for interested seniors only if the Contractor has documented a request to visit by a senior, a caregiver, or a responsible party.

### Prohibited Outreach Activities

The Contractor may not:

#### Offer financial or other incentives to induce Consumers to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor;

#### Directly or indirectly engage in any door-to-door, telephone, e-mail, texting, or other unsolicited or “cold-call” marketing activities;

#### Make any statements, whether written or oral, that is inaccurate, misleading, confusing, or could defraud EOHHS or any MassHealth Member. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement, whether written or oral, that:

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

##### A MassHealth Member must enroll with the Contractor to obtain benefits or to not lose benefits.

#### Seek to influence a Potential Enrollee’s enrollment with the Contractor in conjunction with the sale or offering of any private insurance.

## Financial Requirements

### Financial Viability

#### Minimum Net Worth

The Contractor must have and maintain at all times a net worth that meets the minimum net worth requirements as follows:

##### Prior to entering into this Contract, net worth shall be at least $1,000,000.

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

###### At least $500,000 of the minimum net worth amount must be maintained in cash;

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

###### If at least $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 20% of the minimum net worth required will be allowed; and

###### If less than $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 10% of the minimum net worth required will be allowed.

##### Determination of Net Worth

Net worth must be determined in accordance with generally accepted accounting principles (GAAP) and reported on a quarterly basis to EOHHS in accordance with **Appendix D**. The Contractor shall make available to EOHHS, upon the request of EOHHS at any time during the term of the Contract, documentation sufficient to enable EOHHS to verify or otherwise calculate the net worth of the Contractor.

#### Working Capital Requirements

Throughout the term of this Contract, the Contractor must demonstrate and maintain a positive working capital, subject to the following conditions:

##### If a Contractor's working capital falls below zero, the Contractor must submit a written plan to reestablish a positive working capital balance for approval by EOHHS.

##### EOHHS may take any action they deem appropriate, including termination of the Contract, if the Contractor:

###### Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time;

###### Violates a corrective plan approved by EOHHS; or

###### EOHHS determine that negative working capital cannot be corrected within a reasonable time.

##### Determination of Working Capital

Working capital must be determined in accordance with generally accepted accounting principles (GAAP) and reported on a quarterly basis to EOHHS in accordance with **Appendix D**. The Contractor shall make available to EOHHS, upon the request of EOHHS at any time during the term of the Contract, documentation sufficient to enable EOHHS to verify or otherwise calculate the working capital of the Contractor.

### Financial Stability

#### Financial Stability Plan

##### Throughout the term of this Contract, the Contractor must:

###### Remain financially stable;

###### Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

Provide to Enrollees all Covered Services required by this Contract for a period of at least 45 calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

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

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

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

###### Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any Provider, including, at a minimum, workers’ compensation insurance, comprehensive liability insurance, and property damage insurance.

#### Insolvency Reserve

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

##### EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.

##### The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor’s estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.

##### Subject to EOHHS approval, the Contractor may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; net worth of the Contractor (exclusive of any restricted cash reserves); performance guarantee as specified in Section 2.11.B.3; insolvency insurance or reinsurance; performance bonds; irrevocable letter of credit; and other letters of credit.

#### Performance Guarantees and Additional Security

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

##### A promissory note from the Contractor’s parent(s)/affiliate or a performance bond from an independent agent in the amount of $1,000,000 to guarantee performance of the Contractor’s obligation to provide Covered Services in the event of the Contractor’s impending or actual insolvency; and

##### A promissory note from the Contractor’s parent(s)/affiliate or a performance bond from an independent agent in the amount of $400,000 to guarantee performance of the Contractor’s obligations to perform activities related to the administration of the Contract in the event of the Contractor’s impending or actual insolvency.

### Additional Financial Requirements

#### Auditing and Financial Changes

Throughout the term of this Contract, the Contractor must:

##### Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits must comply with the following requirements and must be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles and generally accepted auditing standards:

###### No later than 120 days after the Contractor’s fiscal year end, the Contractor shall submit to EOHHS its most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement and statement of cash flows that include appropriate footnotes).

###### The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS an attestation report from its independent auditor on the effectiveness of the internal controls over operations of the Contractor related to this Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report; provided, however, if the Contractor is Service Organization Control (SOC) compliant, the Contractor shall annually submit a copy of the SOC report in lieu of the attestation report described above within 30 days of the Contractor’s independent auditors issuing its SOC report.

###### The Contractor shall submit, on an annual basis after each annual audit, the final audit report together with all supporting documentation, a representation letter signed by the Contractor’s chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

##### Report annually, or more frequently when requested by EOHHS, on any significant deficiencies in internal controls as follows:

###### Furnish EOHHS with a written report prepared by the independent auditor that performed the Contractor’s independent financial audit, describing significant deficiencies in the Contractor’s internal control structure noted by the accountant during the audit. No report need be issued if the accountant does not identify significant deficiencies; and

###### Describe in writing the remedial actions it has taken or proposes to take to correct significant deficiencies, if such actions are not described in the accountant’s report. EOHHS may require the Contractor to take additional or different corrective action to correct such deficiencies.

##### Immediately notify EOHHS of any material negative change in the Contractor’s financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency;

##### Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor’s ability to satisfy its payment or performance obligations under this Contract;

##### Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor’s ability to perform under this Contract; and

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

#### Risk Arrangements

The Contractor may maintain Provider risk arrangements. The Contractor must disclose these arrangements to EOHHS as follows.

##### The Contractor must provide a description of any changes in its risk arrangements with all members of its Provider Network, including but not limited to Primary Care, specialists, hospitals, nursing facilities, other long term care Providers, behavioral health Providers, and ancillary services.

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

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

#### Value Based Purchasing Arrangements

EOHHS encourages Contractor to enter into value based payment arrangement. If the Contractor elects to contract with their Providers, Subcontractors or suppliers under a value based purchasing arrangement, it must disclose those arrangements to EOHHS.

#### Physician Incentive Plans

##### The Contractor may, in its discretion, operate a physician incentive plan only if:

###### No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician’s direct control;

###### No specific payment is made directly or indirectly under the plan to a Provider, physician, or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

###### The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 CFR 417 are met.

##### The Contractor and its Subcontractors must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR 438.3(i) and 42 CFR 438.6(b)(2). The Contractor must submit all information required to be disclosed to EOHHS and CMS in the manner and format specified by EOHHS and CMS, which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts and 42 CFR 422.208 and 42 CFR 422.210. The Contractor must provide information on its physician incentive plan to any Enrollee upon request. If the Contractor is required to conduct a beneficiary survey, survey results must be disclosed to EOHHS and to any Enrollee upon request.

##### The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor’s or its Subcontractors’ failure to comply with the requirements governing physician incentive plans at 42 U.S.C. § 1396b(m)(2)(A)(x), 42 CFR Parts 417, 422, 434, 438, and 1003; provided, however, that the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor’s plan; provided, further, that the Contractor shall not be liable if it can demonstrate, to the satisfaction of EOHHS and CMS, that it has made a good faith effort to comply with the cited requirements.

#### Right to Audit and Inspect Books

The Contractor must grant EOHHS the right to audit and inspect its books and records related to:

##### The Contractor's capacity to bear the risk of potential financial losses; and

##### Services performed or the determination of amounts payable under the Contract.

#### Other Information

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

#### Reporting

To demonstrate that the Contractor has met the requirements of this **Section 2.11**, the Contractor must submit to EOHHS all required financial reports, as described in this **Section 2.11** and **Appendix D**, in accordance with specified timetables, definitions, formats, assumptions, and certifications as well as any ad hoc financial reports required by EOHHS.

#### Financial Responsibility for Post-Stabilization Services

The Contractor must pay for post-stabilization services in accordance with 42 CFR 438.114(b) and (e), and 42 CFR 422.113(c)(2) and (3).

#### The Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 USC1395i-4 are an amount equal to at least 101 percent of allowable costs under the Contractor’s plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services.

## Data Submissions, Reporting Requirements, and Surveys

### General Requirements for Data

#### The Contractor must provide and require its Subcontractors to provide any and all information EOHHS requires under the Contract related to the performance of the Contractor’s responsibilities.;

#### The Contractor must provide and require its Subcontractors to provide any and all information EOHHS requires in order to comply with the Balanced Budget Act of 1997, or any other federal or State laws and regulations, including, but not limited to, all data, information, and documentation required pursuant to 42 CFR 438.604.

#### The Contractor must provide and require its Subcontractors to provide EOHHS any and all data to meet all applicable federal and state reporting requirements within the legally required time frames.

#### The Contractor shall collect from its PCM Agencies, and provide to EOHHS upon request, reports as directed by EOHHS. Such reports may include, but are not limited to, the following information:

##### The number of overtime approval requests received; and

##### The number of overtime approval requests submitted to MassHealth.

### General Reporting Requirements

The Contractor must:

#### Be responsible for all administrative costs associated with the development, production, mailing, and delivery of all reports required under the Contract;

#### Submit all required reports in accordance with the specifications, templates, and time frames described in this Contract and Appendix D, unless otherwise directed or agreed to by EOHHS. The Contractor must submit all proposed modifications, revisions, or enhancements to any reports to EOHHS for approval prior to making such changes;

#### If EOHHS does not approve any report the Contractor submits, correct or modify the report as directed by EOHHS and resubmit it to EOHHS for final acceptance and approval within time frames prescribed by EOHHS;

#### At request of EOHHS provide additional ad hoc or periodic reports or analyses of data related to the Contract, according to a schedule and format specified and prescribed by EOHHS;

#### Have the capacity to display data graphically, in tables, and in charts, as directed by EOHHS;

#### Apply generally accepted principles of statistical analysis and tests for statistical significance, as appropriate, to data contained in reports;

#### Ensure that all reports are identified with a cover page that includes at least the following information:

##### Title of the report;

##### Production date of the report;

##### Contact person for questions regarding the report;

##### Data sources for the report;

##### Reporting interval;

##### Date range covered by the report; and

##### Methodology employed to develop the information for the report;

#### Provide with each report a narrative summary of the findings contained in the report, analyses, and actions taken or planned next steps related to those findings;

#### Submit each report electronically in a format and media compatible with EOHHS software and hardware requirements. At the request of EOHHS, also provide an original and printed copy of each report that is:

##### In a loose-leaf binder;

##### Clearly labeled with the titles of the reports it contains; and

##### Has clear separations between reports when more than one report is contained in one binder.

#### Provide EOHHS with reports and necessary data to meet all applicable federal and State reporting requirements within the legally required time frames;

#### Provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS, all reports, data or other information EOHHS determines necessary for compliance with program report requirements set forth in 42 CFR 438.66(e); and

#### Provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to “annual” or “year-to-date” reports or data refer to the Contract Year, unless otherwise specified. EOHHS may at its sole discretion assess financial penalties as described in Section 5.5.Q for failure to perform any reporting requirements.

##### Incident Reports – deliver incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the next business day after the Contractor receives incident notification, in accordance with the established protocol.

##### Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported, if the 20th of the month falls on a non-business day, the next business day; except for October, January, April, and July, when monthly reports may be submitted with quarterly reports.

##### Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, that is, October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Quarterly reports due January 30 and July 30 may be submitted with semiannual reports.

##### Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, that is, January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day.

##### Annual Reports – April 30 or, if April 30 falls on a non-business day, the next business day.

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

### Participation in Surveys

The Contractor agrees to participate in any surveys required by EOHHS and to submit all information requested by EOHHS to administer and evaluate the program. This survey information regarding the Contractor must include, but not be limited to:

#### Plan quality and performance indicators, including:

##### Information on Enrollee satisfaction;

##### The availability, accessibility, and acceptability of services; and

##### Information on health outcomes and other performance measures.

#### Information about Enrollee Appeals and their disposition; and

#### Information regarding formal actions, reviews, findings, or other similar actions by any governmental body, or any certifying or accrediting organization.

### Certification Requirements

#### In accordance with 42 CFR 438.600 et seq., the Contractor’s Chief Executive or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit a certification to EOHHS, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of his or her knowledge, information and belief, after reasonable inquiry:

##### Data on which payments to the Contractor are based, including data on the basis of which the State certifies the actuarial soundness of capitation rates paid to the Contractor;

##### All enrollment information, encounter data, and measurement data;

##### Data related to medical loss ratio requirements;

##### Data or information related to protection against the risk of insolvency, including the data on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency;

##### Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor’s Provider Network;

##### Information on ownership and control, such as that pursuant to Section 5.1.F;

##### Reports related to overpayments; and

##### Data and other information required by EOHHS including, but not limited to, reports and data described in this Contract.

#### The Contractor must submit the certification concurrently with the certified data.

## Required Program Reports

### Clinical Indicator Data

#### The Contractor must report clinical indicator data for all Enrollees in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA). The Contractor must comply with, and report to EOHHS, the HEDIS SNP Measures as required and approved by NCQA and CMS and report to EOHHS on the same time schedule required by CMS.

#### The HEDIS measures in Appendix L, Exhibit 1 must be collected according to HEDIS specifications, and reported to EOHHS on the same time schedule required by CMS.

### Encounter Data

The Contractor shall meet any diagnosis and/or encounter reporting requirements that are mandated by federal or state law, or by EOHHS. This includes the requirements set forth in 42 CFR 438.242(c)(1)-(4), 42 CFR 438.604(a)(1) and 42 CFR 438.818. This also includes the diagnosis and/or encounter reporting requirements that apply to Medicare Advantage plans and Medicaid managed care organizations, as well as the EOHHS Encounter data specifications set forth in **Appendix I**, as may be amended from time to time. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section.

#### The Contractor shall collect and maintain 100% Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data.

#### The Contractor shall participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data.

#### Upon request by EOHHS, or its designee, the Contractor shall provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually.

#### The Contractor shall produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include, but is not limited to, the data elements described in Appendix I, the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the servicing/rendering, referring, prescribing and primary care Provider and any National Drug Code (NDC) information on drug claims. As directed by EOHHS, such Encounter Data shall also include information related to denied claims and 340B Drug Rebate indicators.

#### The Contractor shall provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter data to EOHHS by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter data specifications set forth in Appendix I.

#### The Contractor shall submit Encounter Data that is at a minimum compliant with the standards specified in Appendix O, including but not limited to standards for completeness and accuracy. To meet the completeness standard, all critical fields in the data must contain, at a minimum, valid values. To meet the accuracy standard, the Contractor must have systems in place to monitor and audit claims. The Contractor must also correct and resubmit voided and denied encounters as necessary.

#### If EOHHS, or the Contractor, determines at any time that the Contractor’s Encounter Data is not compliant with the benchmarks described in Appendix O, the Contractor shall:

##### Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

##### Submit for EOHHS approval, within a time frame established by EOHHS which shall in no event exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

##### Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

##### Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is compliant with the benchmarks described in Appendix O. The Contractor may be financially liable for such validation study.

#### The Contractor shall report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid.

#### The Contractor shall submit any correction/manual override file within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter data specifications set forth in Appendix I.

#### EOHHS may, at any time, modify the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Enrollees’ affiliation with their Primary Care Provider.

#### At EOHHS’ request, the Contractor shall submit denied claims, as further specified by EOHHS.

#### EOHHS may impose intermediate sanctions in accordance with Section 5.5.Q based on the completeness, accuracy, timeliness, form, format, and other standards described in this Section. At a time specified by EOHHS, the Contractor shall comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting Encounter Data to include professional, institutional and dental claims and submitting pharmacy claims using NCPDP standards.  This submission may require the Contractor to re-submit Encounter Data previously submitted to EOHHS in alternative formats.

### Consumer Assessment of Healthcare Providers and Services (CAHPS) data

The Contractor must submit the Consumer Assessment of Healthcare Providers and Services (CAHPS) data to EOHHS annually, on the anniversary of the start date of the Contract.

### Grievances and Appeals

#### On a monthly basis, the Contractor must report the number and types of Grievances filed by Enrollees and received by the Contractor, specifying how and in what time frames they were resolved (see Section 2.8). The Contractor must cooperate with EOHHS to implement improvements based on the findings of these reports.

#### The Contractor must report the number, types, and resolutions of Appeals filed, including, for external Appeals, whether the external review was by the CMS Independent Review Entity or by the MassHealth Board of Hearings.

### Functional Data

The Contractor must report the need for assistance with Activities of Daily Living (ADLs) annually for all Enrollees by age and gender. This data will be collected in accordance with the Comprehensive Assessment and will include the number of Enrollees per 1,000 needing limited assistance and number of Enrollees per 1,000 needing extensive or total assistance with:

#### Mobility;

#### Transfer;

#### Dressing;

#### Eating;

#### Toilet use;

#### Personal hygiene; and

#### Bathing.

### Mortality Data

The Contractor must report mortality data annually, by age and gender, in the following categories:

#### The number of Enrollees who died during the past year;

#### Percentage who died in hospitals;

#### Percentage who died in nursing facilities;

#### Percentage who died in non-institutional settings; and

#### Cause of death.

### Medications

The Contractor must report Enrollee-specific prescription data through MDS 2.0 for nursing residents and the MDS-HC for home care.

### Provider Preventable Conditions

Pursuant to 42 CFR 438.3(g), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

### Continuity of Operations Plan

In accordance with **Section 5.3**, the Contractor shall annually submit a copy of its Continuity of Operations Plan at the time of submitting annual reports under **Section 2.12.B.12.e**.

### Compliance Plan

In accordance with **Section 5.2.A**, the Contractor shall annually submit a copy of its Compliance Plan at the time of submitting annual reports under **Section 2.12.B.12.e**.

### Payment Discrepancy Report

The Contractor must report monthly, in a format specified by EOHHS, a list of payment discrepancies.

### Contract Compliance Attestation

The Contractor must submit on a semi-annual basis a Contract Compliance Attestation reporting on measures determined by EOHHS.

### Frail Elder Waiver Reporting

The Contractor shall comply with the quality improvement performance measures as described in the Frail Elder Waiver. The Contractor shall submit a report on its compliance with these quality improvement performance measures in a form and format to be prescribed by EOHHS. The Contractor shall submit these reports semi-annually, as follows:

#### No later than March 31 of each year, the Contractor shall submit a report containing data from the previous calendar year.

#### No later than September 30 of each year, the Contractor shall submit a report containing data from the first six months of the current calendar year.

### Passive Enrollment Report

The Contractor must submit to EOHHS a monthly report on the outcomes of the Contractor’s onboarding activities with regard to members who joined SCO through Passive Enrollment. This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

### Community Support Program (CSP) Report

The Contractor must submit to EOHHS a quarterly report on the outcomes of the Contractor’s activities with regard to the Community Support Program (CSP). This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

### Provider Network Data

The Contractor must submit to EOHHS, on a semi-annual basis, complete provider network data in the format prescribed by EOHHS.

### Medical Loss Ratio (MLR) Requirements

#### Medicaid-Only MLR

##### Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio for those Covered Services for which Medicaid is the payor (Medicaid-only MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such Medicaid-only MLR calculation in the aggregate for the Contractor’s Enrollee population and individually for each Rating Category. By July 31 of each year, the Contractor shall report such Medicaid-only MLR calculations for the prior calendar year to EOHHS in a form and format specified by EOHHS and as set forth in Appendix D. Pursuant to 42 CFR 438.604(a)(3), such report shall include all of the data on the basis of which EOHHS will determine the Contractor’s compliance with the MLR requirement set forth in 42 CFR 438.8, including, but not limited to, the following:

###### Total incurred claims

###### Expenditures on quality improving activities;

###### Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);

###### Non-claims costs;

###### Premium revenue;

###### Taxes, licensing, and regulatory fees;

###### Methodology(ies) for allocation of expenses;

###### Any credibility adjustment applied;

###### The calculated MLR, which shall be the ratio of the numerator (as set forth in Section Section 2.13.Q.1.b.1) to the denominator (as set forth in Section 2.13.Q.1.b.2);

###### Any remittance owed to EOHHS, if applicable;

###### A comparison of the information reported in this Section with the audited financial report required under this Section 2.11.C;

###### A description of the aggregation method used in calculating MLR;

###### The number of member months;

###### An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

###### Any other information required by EOHHS.

##### The Contractor shall calculate its Medicaid-only MLR in accordance with 42 CFR 438.8, as follows:

###### The numerator of the Contractor’s Medicaid-only MLR for each year is the sum of the Contractor’s incurred Medicaid claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

###### The denominator of the Contractor’s Medicaid-only MLR for each year is the difference between the total Medicaid capitation payment received by the Contractor and the Contractor’s federal, state, and local taxes and licensing and regulatory fees, all of which must be calculated in accordance with 42 CFR 438.8.

##### The Contractor shall maintain a minimum Medicaid-only MLR of 85 percent in the aggregate for the Contractor’s Enrollee population. If the Contractor does not maintain such minimum, the Contractor shall be subject to a corrective action plan or sanctions of a value less than or equal to the difference between the Contractor’s actual Medicaid-only MLR numerator and the Medicaid-only MLR numerator that would have resulted in an 85% Medicaid-only MLR for the Contractor.

#### Blended MLR

##### In addition to the Medicaid-only MLR described above, as directed by EOHHS, the Contractor shall calculate and report a Medical Loss Ratio for all Covered Services (regardless of whether Medicare or Medicaid is the payor) in accordance with 42 CFR 438.8 and Section 2.13.Q.1.a-b of this Contract (blended MLR).

##### The Contractor shall calculate its blended MLR in accordance with 42 CFR 438.8, as follows:

###### The numerator of the Contractor’s blended MLR for each year is the sum of the Contractor’s incurred claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

###### The denominator of the Contractor’s blended MLR for each year is the difference between the total capitation payment received by the Contractor and the Contractor’s federal, state, and local taxes and licensing and regulatory fees, all of which must be calculated in accordance with 42 CFR 438.8.

#### At its discretion, EOHHS may use the Contractor’s submitted encounter data to verify the Contractor’s reported Medicaid-only MLR and blended MLR and may impose intermediate sanctions as described in Section 5.5.Q. in circumstance in which encounter data does not support the Contractor’s reported Medicaid-only MLR and/or blended MLR.

## Information Management and Information Systems

### General

The Contractor shall:

Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS’ requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS;

#### Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS;

#### Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information, as specified by EOHHS. If directed by EOHHS, the Contractor shall establish appropriate links on the Contractor’s website that direct users back to the EOHHS website portal;

#### Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS;

#### Actively participate in any EOHHS Systems Workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS, as further directed by EOHHS; and

### Health Information System (HIS) Requirements

The Contractor shall maintain a health information system (HIS) or Information Systems (together, the Contractor’s Systems) as follows:

#### Such Systems shall enable the Contractor to meet all of EOHHS’ requirements as outlined in this Contract. The Contractor’s Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards:

##### The EOHHS Unified Process Methodology User Guide;

##### The User Experience and Style Guide Version 2.0;

##### Information Technology Architecture Version 2.0; and

##### Enterprise Web Accessibility Standards 2.0.

#### The HIS shall collect, analyze, integrate, and report data, including, but not limited to information regarding:

##### Utilization (including Non-Covered Services);

##### Claims;

##### Inquiries, Grievances, Internal Appeals, and BOH Appeals;

##### Disenrollments for reasons other than for loss of MassHealth eligibility;

##### Provider information in order to comply with Section 2.5.E;

##### Services furnished to Enrollees through an Encounter Data system, as specified in Section 2.13.B and Appendix I;

##### Enrollee characteristics, including but not limited to, race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheel chair dependence, and characteristics gathered through such Plan contact with Enrollees, e.g., Care Needs Screenings administered upon enrollment, Care Management, or other reliable means;

##### Enrollee participation in Care Management programs by type of Care Management program, and identification of Enrollees as belonging to any of the special populations or subgroups identified in the definition of Enrollees with Special Health Care Needs;

#### The Contractor shall ensure that data received from Providers is 99% complete and 95% accurate by:

##### Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating on the basis of capitation payments;

##### Screening the data for completeness, logic and consistency; and

##### Collecting data from providers, including service information, in standardized formats to the extent feasible and appropriate or as directed by EOHHS, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

#### The Contractor shall make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(4);

#### As set forth in 42 CFR 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act.

### Design Requirements

#### The Contractor shall comply with EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

#### The Contractor’s Systems shall interface with EOHHS’s legacy Medicaid Management Information System (MMIS) and NewMMIS, the EOHHS Virtual Gateway, and other EOHHS IT architecture.

#### The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files shall include, but are not limited to:

##### Inbound Interfaces

###### Daily Inbound Demographic Change File;

###### HIPAA 834 History Request File;

###### Inbound Co-pay Data File (daily); and

###### Monthly Managed Care Provider Directory.

##### Outbound Interfaces

###### HIPAA 834 Outbound Daily File;

###### HIPAA 834 Outbound Full File;

###### HIPAA 834 History Response;

###### Fee-For-Service Wrap Services;

###### HIPAA 820; and

###### TPL Carrier Codes File.

##### SCO Provider Directory Database

###### Provider types and specialties;

###### Working hours;

###### Languages spoken; and

###### Access for disabled Consumers.

#### The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

#### The Contractor shall demonstrate controls to maintain information integrity.

#### The Contractor shall access the state’s Virtual Gateway to enroll and disenroll members through Direct Data Entry (DDE) or through the HIPAA 834 transaction.

#### The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS.

### System Access Management and Information Accessibility Requirements

#### The Contractor shall make all Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor’s data and Systems.

#### The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

### System Security and Privacy Requirements

The Contractor shall implement administrative, physical and technical safeguards necessary to ensure the confidentiality, availability and integrity of all personally-identifiable data (which shall include, but not be limited to, “protected health information” as such term is defined under HIPAA), as well as any additional security measures required by other state or federal laws or regulations, at EOHHS’s request.

## Responsibilities Related to PCAs Employed by the Contractor’s Enrollees

### The Contractor shall implement a mechanism for receiving, investigating, and responding to complaints, whether formal or informal, alleging non-payment of wages owed to PCAs employed by one or more of the Contractor’s Enrollees.

### In addition to any other indemnity provision within this Contract, the Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any complaint or lawsuit related to the payment of wages to a PCA employed by one or more of the Contractor’s Enrollees, regardless of whether such complaint asserts violations of the Federal Fair Labor Standards Act (29 U.S.C. § 201, et seq.), the Commonwealth’s Wage Act (M.G.L. c. 149, § 148), or any other federal or state law or regulation, provided that:

#### The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim; and

#### The Contractor is afforded an opportunity to participate in the defense of such claims.

# EOHHS RESPONSIBILITIES IN COORDINATION WITH CMS

## Contract Management

### Administration

EOHHS will coordinate contract management with CMS and will:

#### Designate a Contract Management Team that will include, at least one contract officer from EOHHS and one representative from CMS, authorized and empowered to represent CMS and EOHHS about all aspects of the Contract. The CMS representative and the EOHHS representative will act as liaisons between the Contractor and CMS and EOHHS for the duration of the Contract. The Contract Management Team will:

##### Monitor compliance with the terms of the Contract. EOHHS will be responsible for the day-to-day monitoring of the Contractor’s performance and will periodically report to CMS and the Executive Office of Elder Affairs. CMS will communicate directly with the Contractor as necessary;

##### Receive and respond to all inquiries and requests made by the Contractor under this Contract in a timely manner;

##### Meet with the Contractor's Director on a periodic or as-needed basis, resolving issues that arise;

##### Coordinate requests for assistance from the Contractor and assign staff with appropriate expertise to provide technical assistance to the Contractor;

##### Make best efforts to resolve any issues applicable to the Contract identified by the Contractor; and

##### Inform the Contractor of any discretionary action by EOHHS or CMS under the provisions of the Contract;

#### Review, approve, and monitor the Contractor’s Outreach and orientation materials and procedures;

#### Review, approve, and monitor the Contractor’s Grievance and Appeals procedures;

#### Apply one or more of the sanctions provided in Section 5.5.Q, including termination of the Contract in accordance with Section 5.7, if CMS and EOHHS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

#### Conduct site visits of the Contractor annually, or as determined necessary to verify the accuracy of reported data;

#### Coordinate the Contractor’s external quality reviews conducted by the external quality review organization;

#### At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data including comparing utilization data from medical records of Enrollees (chosen randomly by EOHHS) with the Encounter Data provided by the Contractor. If EOHHS determines that the Contractor’s Encounter Data are less than 99% complete or less than 95% accurate, EOHHS will provide the Contractor with written documentation of its determination and the Contractor shall be required to implement a corrective action plan to bring the accuracy to the acceptable level. EOHHS may conduct a validity study following the end of a twelve month period after the implementation of the corrective action plan to assess whether the Contractor has attained 99% completeness. EOHHS, at its discretion, may impose intermediate sanctions or terminate the Contract if the Contractor fails to achieve a 95% accuracy level following completion of the corrective action plan as determined by the validity study or as otherwise determined by EOHHS;

#### If it determines that the Contractor is out of compliance with Section 5.1.E. of the Contract, notify the Secretary of such non-compliance and determine the impact on the term of the Contract in accordance with Section 5.7 of the Contract; and

#### EOHHS shall notify the Contractor, as promptly as is practicable, of any Providers suspended or terminated from participation in MassHealth so that the Contractor may take action as necessary, in accordance with Section 2.5.B.1.f.

### Performance Evaluation

EOHHS, in coordination with CMS will, at their discretion:

#### Evaluate, through inspection or other means, the Contractor’s compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.12 and 2.13, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. EOHHS will coordinate with CMS to provide the Contractor with the written results of these evaluations;

#### Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

#### Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and

#### Meet with the Contractor at least semi-annually to assess the Contractor’s performance.

## Enrollment, Disenrollment, and Rating Category Determinations

EOHHS and CMS will maintain separate systems to provide:

### Enrollment, disenrollment, and rating-category determinations;

### Enrollment, disenrollment, rating-category determination information to the Contractor; and

### Continuous verification of eligibility status.

## Outreach

EOHHS will coordinate with CMS to:

### Monitor the Contractor’s Outreach activities and distribution of related materials;

### Coordinate Outreach monitoring activities, as described in Section 2.10;

### Conduct an ongoing review of Outreach activities, including:

#### Approval of all Outreach materials, in all forms, prior to use;

#### Random onsite review of Outreach forums, products, and activities;

#### Random review of actual Outreach pieces as they are used in or by the media; and

#### For-cause review of materials and activities when complaints are made by any source; and

### If EOHHS or CMS find that the Contractor is violating these requirements, monitor the development and implementation of a corrective action plan.

# PAYMENT AND FINANCIAL PROVISIONS

## General Financial Provisions

### Capitation Payments

EOHHS will make monthly capitation payments to the Contractor in accordance with the rates of payment and payment provisions set forth herein and in **Appendix N** for all Covered Services actually and properly delivered to eligible Enrollees in accordance with and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive two monthly capitation payments for each Dual Eligible Enrollee: one amount from Medicare and a second amount from MassHealth. Medicare and MassHealth each produce different Rate Cells (RCs). For those Enrollees who are eligible for MassHealth only, the Contractor will receive one monthly capitation payment from MassHealth.

### Modifications to Capitation Rates

EOHHS will notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates by RC. Updated MassHealth Capitation Rates will be established by amendment to this Contract.

### Health Insurer Provider Fee Adjustment

Each year, to account for the portion of the Contractor’s Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to capitation payments made by EOHHS to the Contractor under this Contract, if the Contractor is subject to such HIPF:

#### Each year, the Contractor shall provide EOHHS with information about the Contractor’s HIPF, as requested by EOHHS, including but not limited to the bill the Contractor receives from the U.S. Internal Revenue Service.

#### EOHHS shall calculate and perform an adjustment set forth in Appendix E, Exhibit 1 to the Contractor’s Base Capitation Rates to account for the portion of the Contractor’s HIPF that is allocable to capitation payments made by EOHHS to the Contractor under this Contract and, subject to federal financial participation, for the tax liability related to the HIPF, if applicable.

#### For Calendar Year 2014, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after April 22, 2016.

#### For Calendar Year 2015, such adjustment shall be a retroactive, one-time adjustment made as a single payment on or after April 22, 2017.

## Medicare Payment

To obtain payment from Medicare, the Contractor shall comply with the Medicare-Advantage-Part D provisions.

## Payment Terms

EOHHS will make monthly capitation payments to the Contractor. The MassHealth capitation payment for each RC will be the product of the number of Enrollees in each category multiplied by the payment rate for that RC. Patient contribution to care amounts will be deducted from the total MassHealth monthly capitation payment amount, in accordance with **Section 4.3.B**.

### Timing of Capitation Payments

#### New Enrollments

EOHHS will make capitation payments for Enrollees. Enrollments received and approved by EOHHS on or before the last business day of the month will be effective the first calendar day of the following month. EOHHS will make monthly capitation payments to the Contractor for the month beginning on the effective date of enrollment.

#### Disenrollments

If a disenrollment form is signed by the Enrollee (or Enrollee’s representative) and submitted to EOHHS on or before the last business day of the month, the disenrollment will be effective on the first calendar day of the following month. The final capitation payment made by EOHHS to the Contractor for this Enrollee will be for the month in which the disenrollment was submitted.

#### After an Enrollee’s Death

If an Enrollee dies, he or she will be disenrolled as of the date of his or her death. EOHHS’s final capitation payment for an Enrollee who dies will be for the month in which the Enrollee died. The Contractor is not entitled to capitation payments for subsequent months. In addition, EOHHS will calculate a revised, pro-rated monthly capitation payment for the month in which the Enrollee died, to reflect the number of days that month in which the Enrollee was enrolled with the Contractor. As part of the reconciliation process described in **Section 4.4**, EOHHS will recoup the difference between this pro-rated monthly capitation payment and the capitation payment received by the Contractor on account of that Enrollee.

### Patient Contribution to Care Amounts

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

### American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions below, 42 CFR 438.14, and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. The Contractor shall:

#### Offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain Covered Services from out-of-network Indian Health Care Providers from whom the Enrollee is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider;

#### Demonstrate that there are sufficient Indian Health Care Providers participating in its Provider Network to ensure timely access to services available under this Contract from such providers for Indian Enrollees who are eligible to receive such services;

#### Pay both network and non-network Indian Health Care Providers who provide SCO Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the SCO Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;

#### Make prompt payment to Indian Health Care Providers; and

#### Pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 CFR 438.14(c)(1).

## Reconciliation

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

### MassHealth Capitation Reconciliation

EOHHS will:

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

##### Calculate the correct Capitation Rate for each month per Enrollee by determining the Enrollee’s appropriate RC and the appropriate patient contribution; and

##### Reconcile the monthly Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate as calculated in Section 4.4.A.1.a above; and

#### Remit to the Contractor the full amount of any underpayment it identifies pursuant to Section 4.4.A.1.a. The Contractor must remit to EOHHS the full amount of any overpayments identified by EOHHS pursuant to Section 4.4.A.1. Such payment shall be made through a check or other funds transfer method acceptable to EOHHS, or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.

#### EOHHS at its discretion may choose to perform other periodic reconciliations of the monthly capitation payments.

### Audits

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

## Federal Payment Approval

The federal government requires that states meet certain state plan requirements and certify to the federal government that MassHealth capitation payments do not exceed the cost of providing Covered Services on a fee-for-service basis to an actuarially equivalent population. If any portion of the MassHealth capitation payment methodology is not approved by CMS, any payment made by EOHHS in excess of the MassHealth payments resulting from the federally approved methodology will be deemed an overpayment. EOHHS may collect such overpayment through a deduction from future payments to the Contractor.

## Payment in Full

The Contractor must accept, as payment in full for all obligations under this Contract, the MassHealth Capitation Rates and the terms and conditions of payment set forth herein.

# ADDITIONAL TERMS AND CONDITIONS

## Administration

### Notification of Administrative Changes

The Contractor must notify EOHHS and CMS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify EOHHS and CMS in writing no later than 30 calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a Subcontractor pursuant to **Section 2.5.C.3**. The Contractor must notify EOHHS and CMS in writing of all other changes no later than five business days prior to the effective date of such change.

### Assignment

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

### Independent Contractors

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

### Subrogation

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

#### Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

#### Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

##### Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

##### Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

### Prohibited Affiliations

In accordance with 42 USC §1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, provider, subcontractor, or other agreement for the provision of items and services that are significant and material to the Contractor’s obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the Contractor’s equity or be permitted to serve as a director, officer, or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any prohibited affiliations identified by the Contractor.

The Contractor warrants and represents that it will not, in accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, knowingly have an employment, consulting, provider, subcontractor, or other agreement for the provision of items and services that are significant and material to the Contractor’s obligations under this Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded, under federal or state law, regulation, executive order, or guidelines, from certain procurement and non-procurement activities. The Contractor further warrants and represents that no such person may have beneficial ownership of more than five percent of the Contractor’s equity nor be permitted to serve as a director, officer or partner of the Contractor. In the event that EOHHS learns that the Contractor has a prohibited affiliation with a person or entity who is debarred, suspended, or excluded from participating in federal healthcare programs, EOHHS (a) must notify the Secretary of the noncompliance, (b) may continue the SCO Contract unless the Secretary directs otherwise, and (c) may not renew or extend the SCO Contract unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b). The Contractor further warrants and represents that the Contractor does not meet any of the conditions set forth in 42 CFR 438.808(b).

### Disclosure Requirements

#### The Contractor shall within one business day disclose to EOHHS any non-compliance by the Contractor with any provision of this Contract, or any state or federal law or regulation governing this Contract.

#### The Contractor shall make the following federally-required disclosures in accordance with 42 CFR § 455.100, et seq., 42 CFR 1002.3 and 42 USC § 1396b(m)(4)(A) in the form and format specified by EOHHS.

##### Ownership and Control

Upon the Contractor’s submission of a proposal in accordance with the State’s procurement process, upon the Contractor’s execution of this Contract, upon any renewal or extension of this Contract, and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, both with respect to the Contractor and Subcontractors.

##### Business Transactions

Within 35 days of a written request by EOHHS and/or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to EOHHS, or the U.S. Department of Health and Human Services, as required by 42 CFR 455.105 regarding business transactions.

##### Criminal Convictions

Upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.

##### Sanctioned Individuals

Upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 1002.3, regarding sanctioned individuals as described under 42 CFR 1001.1001(a)(1).

##### Other Disclosures

The Contractor shall comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. Pursuant to 42 U.S.C. § 1396b(m)(4)(B), the Contractor shall make any information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to Enrollees upon reasonable request.

#### Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in Section 5.1.F.2.a-e, above, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose, the current version of which is attached hereto as Appendix G. EOHHS may update or replace Appendix G without the need for a Contract amendment.

#### EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this Section 5.1.F or in response to the information contained in the Contractor’s disclosures under this Section 5.1.F. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

### Physician Identifier

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

### Timely Payments to Contracted Providers

The Contractor must make payment on a timely basis to Providers for SCO Covered Services furnished to Enrollees, in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. Unless otherwise provided for and mutually agreed to in an agreement between the Contractor and a Provider, the Contractor must ensure that 90% of payment claims from physicians, who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within 90 days of the date of receipt of the claim. The Contractor and its contracted Providers may by mutual agreement, in writing, establish an alternative payment schedule.

### Protection of Enrollee-Provider Communications

#### In accordance with 42 USC §1396 u-2(b)(3), the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following:

##### The Enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

##### Any information the Enrollee needs in order to decide among all relevant treatment options;

##### The risks, benefits, and consequences of treatment or non-treatment; and

##### The Enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

#### Notwithstanding the provisions of Section 5.1.I.1 above, and subject to the requirements set forth below, the Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows:

##### To EOHHS:

###### With its application for a Medicaid contract; and

###### At least 60 days prior to adopting the policy during the term of the Contract.

##### To Potential Enrollees, via enrollment materials, at least 30 days prior to adopting the policy during the term of the Contract.

##### To Enrollees, at least 30 days prior to adopting the policy during the terms of the Contract.

### Protecting Enrollee from Liability for Payment

The Contractor must:

#### In accordance with 42 USC §1396 u-2(b)(6), not hold an Enrollee liable for:

##### Debts of the Contractor, in the event of the Contractor’s insolvency;

##### Services (other than Excluded Services) provided to the Enrollee in the event that the Contractor fails to receive payment from EOHHS or CMS for such services; or

##### Payments to a clinical Subcontractor in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

#### Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Section 5.1.J.5 below;

#### Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

#### Not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a bill that has not been paid;

#### Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to identify and sanction any member of the Contractor’s Provider Network that does not comply with such provisions; and

#### Ensure that any cost-sharing imposed on Enrollees is in accordance with 42 CFR 447.50 through 447.82.

### Payments to Federally Qualified Health Centers and Rural Health Centers

The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 114.3 CMR 4.00, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

### Accreditation

#### The Contractor shall inform the State whether it has been accredited by a private independent accrediting entity, including but not limited to NCQA accreditation.

#### If the Contractor has received accreditation by a private independent accrediting entity, the Contractor must authorize that accrediting entity to provide the State a copy of its most recent accreditation review, including:

##### Its accreditation status, survey type, and level (if applicable);

##### Recommended actions or improvements, corrective action plans, and summaries of findings; and

##### The expiration date of the accreditation.

## Program Integrity, Fraud and Abuse Prevention, Detection and Reporting

### General Provisions

The Contractor shall:

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

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

#### Have written internal controls and policies and procedures in place that are designed to prevent, detect , reduce, investigate, correct and report known or suspected fraud, waste and abuse activities.

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

#### Meet with EOHHS at least quarterly to discuss fraud, waste and abuse, audits, and overpayment issues.

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

### Compliance Plan and Anti-Fraud, Waste, and Abuse Plan

In accordance with this Section, the Contractor shall have in place a compliance plan and an anti-fraud, waste, and abuse program plan, copies of which shall be provided to EOHHS, in a form and format specified by EOHHS, by the Contract Operational Start Date and annually thereafter. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

#### Compliance Plan

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

##### Written policies, procedures, and standards of conduct that articulate the Contractor’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements;

##### The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Contractor’s Chief Executive Officer and its board of directors;

##### The establishment of a regulatory compliance committee on the Contractor’s board of directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under this Contract;

##### Adequate Massachusetts-based staffing and resources to investigate incidents and develop and implement plans to assist the Contractor in preventing and detecting potential fraud, waste, and abuse activities. Staff conducting program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on fraud, waste and abuse;

##### A system for training and educating the Contractor’s compliance officer, senior management, and employees regarding applicable federal and state law and regulations, and the requirements under this Contract;

##### Effective lines of communication between the compliance officer and the Contractor’s employees;

##### Enforcement of standards through well-publicized disciplinary guidelines;

##### Establishment and implementation of a system with dedicated staff for:

###### Routine internal monitoring and auditing of compliance risks;

###### Prompt response to compliance problems as identified in the course of self-evaluation and audits;

###### Correction of such problems promptly and thoroughly (and, if necessary, coordination with law enforcement agencies) to reduce the potential for recurrence; and

###### Ongoing compliance with the requirements under this Contract.

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

#### Provider and Enrollee Fraud and Abuse Prevention, Detection and Reporting

The Contractor shall:

##### Develop and maintain a comprehensive internal anti-fraud, waste and abuse program plan to detect and prevent fraud, waste, and abuse by Network Providers, Subcontractors, and Enrollees. At a minimum, this program shall:

###### Require the reporting of suspected and confirmed fraud, waste, and abuse in accordance with this Contract;

###### Require a risk assessment of the Contractor’s various fraud, waste, and abuse and program integrity processes that, among other things, shall identify the Contractor’s three most vulnerable areas, and an outline of action plans to mitigate such risks. The Contractor shall submit this risk assessment to EOHHS on a quarterly basis. The Contractor shall also submit this risk assessment at EOHHS’s request and immediately after identifying a program integrity-related issue, including those that are financial-related (such as overpayment, repayment and fines). If submitting a risk assessment in response to a program integrity-related issue, the Contractor shall also describe the issue; describe its methods for educating its employees regarding federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, abuse, and waste; and provide assurances that all of its officers, directors, managers and employees know and understand the provisions of the Contractor’s compliance and fraud, waste, and abuse plans;

###### Outline activities for:

Educating Providers regarding federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, waste, and abuse, and

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

###### Contain procedures designed to prevent and detect fraud, waste, and abuse in the administration and delivery of services under this Contract; and

###### Include a description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

A list of automated pre-payment claims edits;

A list of automated post-payment claims edits;

A description of desk audits performed on post-processing review of claims;

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

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

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

##### Report no later than five business days to EOHHS, in accordance with all other Contract requirements, all overpayments (including capitation payments or other payments in excess of amounts specified in this Contract) identified and/or recovered, specifying those overpayments attributable to potential fraud;

##### Report promptly to EOHHS, in accordance with all other Contract requirements, when it receives information about an Enrollee’s circumstances that may affect the Enrollee’s MassHealth eligibility;

##### Report no later than five business days to EOHHS, in accordance with all other Contract requirements, when it receives information about a Provider’s circumstances that may affect its ability to participate in the Contractor’s network or in MassHealth;

##### Verify, in accordance with other Contract requirements, through sampling, whether services that were represented to be delivered by Providers were received by Enrollees;

##### Provide employees, subcontractors, and agents detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including whistleblower protections;

##### Report within five business days to EOHHS, in accordance with all other Contract requirements, any potential fraud, abuse, or waste that the Contractor identifies or, in accordance with EOHHS policies, directly to the Medicaid Fraud Unit;

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

##### In accordance with M.G.L. c. 12, § 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority’s investigation or prosecution;

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

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

##### Make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful or abusive actions by the Contractor, or its parent organization, its Providers or its subcontractors;

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

##### Submit on an quarterly basis a fraud and abuse report according to the format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS in accordance with Appendix D;

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

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

##### Require, and develop a mechanism to enable, a Provider to:

###### Report to the Contractor when it has received an overpayment;

###### Return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified; and

###### Notify the Contractor in writing of the reason for the overpayment;

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

##### Report annually to EOHHS, in a form and format specified by EOHHS, on the Contractor’s recoveries of overpayments in accordance with 42 CFR 438.608.

#### Retention of Overpayments and Recovery

If the Contractor identifies an overpayment prior to EOHHS, the Contractor is to recover the overpayment and may retain any overpayments collected. Date of identification and collection must be reported quarterly on the Fraud and Abuse report.

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

##### If EOHHS identifies an overpayment prior to the Contractor, the Commonwealth will explore options up to and including recovering the overpayment from the Contractor.

### Employee Education about False Claims Laws

#### The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 USC §1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least $5 million during the prior Federal fiscal year.

#### If the Contractor is subject to such federal requirements, the Contractor must:

##### On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in a form acceptable to EOHHS and signed under the pains and penalties of perjury, of compliance with such federal requirements;

##### Make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 USC §1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and

##### Initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

#### Failure to comply with this section may result in intermediate sanctions in accordance with this Contract.

### Fraud and Abuse Prevention Coordinator

The Contractor shall designate a Fraud and Abuse prevention coordinator responsible for the following activities. Such coordinator may be the Contractor’s compliance officer.

#### Assessing and strengthening internal controls to insure claims are submitted and payments properly made;

#### Developing and implementing an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and/or Enrollee Fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

#### Conducting regular reviews and audits of operations to guard against Fraud and Abuse;

#### Receiving all referrals from employees, Enrollees or Providers involving cases of suspected Fraud and Abuse and developing protocols to triage all referrals involving suspected Fraud and Abuse;

#### Educating employees, Providers and Enrollees about Fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per M.G.L. c. 12, § 5J; and

#### Establishing mechanisms to receive, process, and effectively respond to complaints of suspected Fraud and Abuse from employees, Providers and Enrollees and report such information to EOHHS.

### Obligation to Screen Employees and Contractors

The Contractor shall use, and shall require its Providers to use, the OIG List of Excluded Individuals Entities (LEIE) upon initial hiring or contracting and on an ongoing monthly basis to screen employees and contractors, including providers and subcontractors, to determine if any such individuals or entities are excluded from participation in federal health care programs. The Contractor shall notify EOHHS of any discovered exclusion of an employee, contractor, or Provider within two business days of discovery.

## Continuity of Operations Plan

The Contractor shall maintain a continuity of operations plan that addresses how the Contractor and its Subcontractors’ operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. In accordance with **Section 2.13.I**, the Contractor shall provide copies of such plan to EOHHS annually on the anniversary of the start date of the Contract and shall inform EOHHS whenever such plan must be implemented.

## Privacy and Security of Personal Data and HIPAA Compliance

### Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health information), including, but not limited to, requirements set forth in M.G.L. c. 66A, 42 CFR 431, Subpart F, and 45 CFR Parts 160, 162 and 164. The Contractor understands and agrees that EOHHS may require specific written assurances and further agreements regarding the security and privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 CFR, parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in course of fulfilling its obligations under this Contract in accordance with applicable State and federal laws.

### Personal Data

The Contractor must annually inform and provide training to each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to the confidentiality of protected health information under HIPAA.

### Data Security

The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member or Enrollee names.

### Return of Personal Data

The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of EOHHS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by EOHHS, will destroy such data or material.

## General Terms and Conditions

### Applicable Law

The term "applicable law," as used in this Contract, means, without limitation, all statutes, orders, rules and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, all applicable law includes Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the Byrd Anti-Lobbying Amendment; Equal Employment Opportunity requirements, as provided in 41 CFR 60; and Titles XVIII and XIX of the Social Security Act.

### Massachusetts Law

The laws of the Commonwealth of Massachusetts govern this Contract, including all rights, obligations, matters of construction, validity, and performance.

### Massachusetts Appropriations Law

All MassHealth Contract payments hereunder are subject to appropriation pursuant to M.G.L. c.29, §26, and will be limited to the amount appropriated therefore to the extent permitted under applicable federal and State laws.

### Sovereign Immunity

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts or EOHHS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

### Advance Directives

The Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The Contractor shall provide Enrollees with written information on advance directives policies, including a description of applicable state law. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

### Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its Subcontractors incurs loss of licensure at any of the Contractor’s facilities or loss of necessary federal or State approvals, the Contractor must report such loss to EOHHS and CMS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.7**.

### Indemnification

The Contractor shall indemnify and hold harmless EOHHS, CMS, the federal government, and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS and CMS, or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its Subcontractors provided that:

#### The Contractor is notified of any claims within a reasonable time from when EOHHS and CMS become aware of the claim; and

#### The Contractor is afforded an opportunity to participate in the defense of such claims.

### Prohibition against Discrimination

#### In accordance with 42 USC §1396 u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any medical care practitioner who is acting within the scope of the practitioner’s license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines a request to include individual or groups of practitioners in its network, it must give the affected practitioners written notice of the reasons for its decision. This section shall not be construed to prohibit the Contractor from including Providers only to the extent necessary to meet the needs of the Contractor’s Enrollees, or from using different reimbursement for different Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

#### If a complaint or claim against the Contractor is presented to the Massachusetts Commission Against Discrimination (MCAD), the Contractor shall cooperate with MCAD in the investigation and disposition of such complaint or claim.

#### In accordance with 42 USC § 1396u-2, 42 CFR 438.3(d), 42 CFR 438.210(a)(3)(ii), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate against, and will not use any policy or practice that has the effect of discriminating against, a MassHealth Member eligible to enroll in the Senior Care Options Program on the basis of health status, need for health care services, diagnosis, illness, race, color, sex, sexual orientation, gender identity, disability, or national origin.

### Anti-Boycott Covenant

During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, EOHHS will be entitled to rescind this Contract in the event of noncompliance with this **Section 5.5.I**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

### Information Sharing

During the course of an Enrollee’s enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and State laws, the Contractor must arrange for the transfer, at no cost to EOHHS, or the Enrollee, of medical information regarding such Enrollee to any subsequent Provider of medical services to such Enrollee, as may be requested by the Enrollee or such Provider or directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to Enrollees who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee’s medical records in a timely manner.

### Other Contracts

Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide EOHHS with a complete list of such plans and services, upon request. EOHHS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other Provider, in the same Service Area.

### Intellectual Property

#### Contractor Property and License

##### The Contractor will retain all right, title and interest in and to all intellectual property developed by it, (i) for clients other than the Commonwealth, and (ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such work product (hereinafter the “Contractor Property”). EOHHS acknowledges that its possession or use of Contractor Property will not transfer to it any title to such intellectual property.

##### Except as expressly authorized in this Contract, EOHHS will not use, copy, modify, publicly display, publicly perform, distribute, transmit or transfer by any means, display, or sublicense the Contractor Property.

##### The Contractor grants EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works based upon the Contractor Property, in any media now known or hereafter known, but only to the extent reasonably necessary for EOHHS’s purposes pursuant to this Contract.

##### Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS’s use of the Contractor Property under the license created herein, the Contractor shall have all the rights and incidents of ownership with respect to the Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

#### EOHHS Property

##### In conformance with the Commonwealth Terms and Conditions, except for the Contractor Property, the Contractor acknowledges and agrees that any and all tasks, deliverables and other work product (which includes, but is not limited to, all reports, summaries, documentation, outlines, plans, processes, know-how, methodologies, layouts, presentations, designs, graphics, specifications, results, user manuals, training materials, work flows, data flows and content) created for or provided to EOHHS by the Contractor or, where applicable, any of its Subcontractors as a result of the Contractor’s performance of the services described herein, or other obligation set forth in this Contract (collectively “EOHHS Property”) are “works made for hire” as such term is defined in the U.S. Copyright Act, and all right, title and interest in the EOHHS Property shall belong to EOHHS. If any EOHHS Property is not subject to the “works made for hire” provisions of the Copyright Act, the Contractor hereby assigns, on behalf of itself and its Subcontractors, to EOHHS, all right, title and interest the Contractor or its Subcontractors may now have or hereafter acquire in and to all such EOHHS Property and the results of all services provided by the Contractor or its Subcontractors hereunder. The Commonwealth of Massachusetts and its assignees shall be the sole owner of all patents, copyrights, trademarks, trade secrets, and other rights and protection in the EOHHS Property. The Contractor agrees to assist EOHHS to obtain and enforce patents, copyrights, trademarks, trade secrets, and other rights and protection relating to such EOHHS Property, and, to that end, the Contractor shall execute all documents used in applying for and obtaining such patents, copyrights, trademarks, trade secrets and other rights and protection on and enforcing such EOHHS Property as EOHHS may desire, together with any assignments thereof to EOHHS.

##### To the extent that any Contractor or third-party intellectual property (collectively, the “Third Party Property”) is contained in any EOHHS Property, the Contractor hereby grants to EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works of the Third Party Property. Nothing in the foregoing provisions restricts EOHHS from licensing the EOHHS Property or Third Party Property to the U.S. Department of Health and Human Services or any other federal or state agency in accordance with applicable regulations. The Contractor hereby represents and warrants that it has obtained all necessary rights and clearances and has the authority to grant the rights and licenses to the EOHHS Property and the Third Party Property as described herein.

##### All data acquired by the Contractor from EOHHS or from others in the performance of this Contract (including personal data, if any) remain the property of EOHHS. The Contractor agrees to provide EOHHS free and full access at all reasonable times to all such data, regardless of whether the data is stored by the Contractor or, where applicable, its Subcontractors.

##### The Contractor shall not disseminate, reproduce, display or publish any EOHHS Property except in accordance with the terms and pursuant to its obligations under this Contract without the prior written consent of EOHHS.

##### The Contractor shall not use EOHHS-owned data, materials and documents, before or after termination or expiration of this Contract, except as required for the performance of the services thereunder.

##### The Contractor shall return to EOHHS promptly, but in any event no later than one week after EOHHS’s request, EOHHS-owned or Commonwealth-owned data, and EOHHS Property. If such return is not feasible, the Contractor shall, at EOHHS’s direction, destroy all EOHHS- or Commonwealth-owned data and/or EOHHS Property.

### Counterparts

This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

### Entire Contract

This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

### No Third-Party Rights or Enforcement

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party’s obligations under this Contract.

### Corrective Action Plan

If, at any time, EOHHS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. EOHHS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by EOHHS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by EOHHS as described in **Section 5.7**, or other intermediate sanctions as described in **Section 5.5.Q**.

### Intermediate Sanctions

#### In addition to termination under Section 5.7, EOHHS may, in their sole discretion, impose any or all of the sanctions in Section 5.5.Q.2 upon any of the events below; provided, however, that EOHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Before imposing any sanction, EOHHS shall give the Contractor timely written notice that explains the basis and nature of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:

##### Fails substantially to provide Covered Services required to be provided under this Contract or under law to Enrollees;

##### Imposes co-payments, premiums or other charges on Enrollees in excess of any permitted under this Contract;

##### Discriminates among Enrollees on the basis of health status or need for health care services;

##### Misrepresents or falsifies information provided to CMS or EOHHS;

##### Misrepresents or falsifies information provided to Enrollees, MassHealth Members, or its Providers;

##### Fails to comply with requirements regarding physician incentive plans);

##### Fails to comply with requirements regarding Provider-Enrollee communications;

##### Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

##### Violates restrictions or other requirements regarding marketing;

##### Fails to comply with quality management requirements consistent with Section 2.9;

##### Fails to comply with any corrective action plan required by EOHHS;

##### Fails to comply with financial solvency requirements;

##### Fails to comply with any other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations;

##### Fails to comply with the False Claims provision of the Deficit Reduction Act of 2005;

##### Fails to comply with reporting requirements;

##### Fails to meet any of the standards for data submission described in this Contract, including accuracy, completeness, timeliness, and other standards for Encounter Data described in Section 2.13 and Appendices I and O;

##### Fails to achieve the minimum Medicaid-only MLR set in Section 2.13.Q.1.c; or

##### Fails to comply with any other requirements of this Contract.

#### In accordance with 42 CFR 438.700 and 42 CFR 438.702, sanctions may include, but are not limited to:

##### Civil money penalties in accordance with 42 CFR 438.704;

##### Financial measures EOHHS determines are appropriate to address the violation;

##### The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 USC §1396 u-2(e)(2)(B) and 42 CFR 438.706;

##### Notifying the affected Enrollees of their right to disenroll;

##### Suspension of enrollment (including assignment of Enrollees);

##### Suspension of payment to the Contractor;

##### Disenrollment of Enrollees;

##### Service Area limitations;

##### Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance;

##### Deducting and withholding a percentage of the Contractor’s Capitation Payment; and

##### Such other measures as EOHHS determines appropriate to address the violation.

#### If EOHHS has identified a deficiency in the performance of a Subcontractor and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.5.P, EOHHS may:

##### Require the Contractor to subcontract with a different Subcontractor deemed satisfactory by EOHHS; or

##### Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

#### In accordance with 42 CFR.438.726, capitation payments to the Contractor will be denied by EOHHS for new Enrollees when, and for so long as, payment for those Enrollees is denied to EOHHS by CMS under 42 CFR 438.730(e):

##### If a CMS determination that the Contractor has acted or failed to act as described in Section 5.5.Q.1.a-f of this Contract is affirmed on review pursuant to 42 CFR 438.730(d).

##### If a CMS determination that the Contractor has acted or failed to act as described in Section 5.5.Q.1.a-f of this Contract is not timely contested by the Contractor under 42 CFR 438.730(c).

##### For the purposes of this subsection, New Enrollee shall be defined as an Enrollee that applies for enrollment after the Effective Date of this Sanction (the date determined in accordance with 42 CFR 438.730(f)).

#### In the event that EOHHS seeks to impose an intermediate sanction solely because the Contractor engaged in the conduct described in Section 5.5.Q.1.m (failure to comply with any other requirements of sections 1903(m) or 1932 of the Medicaid Act), EOHHS may impose only the following sanctions:

##### Granting Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll;

##### Suspending all new enrollments, including default enrollment, after the effective date of the sanction; and/or

##### Suspending payments for all Enrollees who enroll after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

#### Before imposing any of the intermediate sanctions specified in this section, EOHHS shall give the Contractor written notice that explains the basis and nature of the sanctions not less than 14 calendar days before imposing such sanction.

### Additional Administrative Procedures

EOHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

### Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

### Conflict of Interest

#### Neither the Contractor nor any Subcontractor may, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive.

#### In accordance with 42 U.S.C. § 1396u-2(d)(3) and 42 CFR 438.58, EOHHS will implement safeguards against conflicts of interest on the part of its officers and employees who have responsibilities relating to the Contractor or any Subcontractor that are at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy (41 U.S.C. § 423).

### Insurance for Contractor's Employees

The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of EOHHS, provide certification of professional liability insurance coverage.

### Key Personnel

If the Contractor wishes to substitute another individual for the Director of the Senior Care Options Program, identified in **Section 2.2**, the compliance officer, identified in **Section 5.2.B.1.b**, or the medical director, identified in **Section 2.9.C.2.b**,the Contractor must notify EOHHS and CMS immediately and provide the name of a suitable replacement. Upon EOHHS or CMS request, the Contractor must provide EOHHS and CMS with the resumé of the proposed replacement and offer EOHHS and CMS an opportunity to interview the person. If EOHHS and CMS are not reasonably satisfied that the proposed replacement has ability and experience comparable to the originally approved personnel, EOHHS and CMS will notify the Contractor within 10 business days after receiving the resumé and completing any interview. The Contractor must then propose another replacement for approval. This process must be repeated until EOHHS and CMS approve new key personnel.

If EOHHS and CMS are concerned that the Director of the Senior Care Options Program, identified in **Section 2.2**, the compliance officer, identified in **Section 5.2.B.1.b**, or the medical director, identified in **Section 2.9.C.2.b** is not performing responsibilities required by this Contract, EOHHS and CMS will inform the Contractor of this concern. The Contractor must investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS and CMS of such actions. If the Contractor’s actions fail to ensure full compliance with the terms of this Contract, as determined by EOHHS and CMS, the corrective action provisions in **Section 5.5.P** will be invoked by EOHHS and CMS.

### Waiver

The Contractor, EOHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, EOHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by EOHHS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

### Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

## Record Retention, Inspection, and Audit

### The Contractor, and its subcontractors, shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

### Pursuant to 42 CFR 438.3(h), EOHHS, other representatives from the Commonwealth of Massachusetts, CMS, the Office of the Inspector General, the Comptroller General, and their designees, shall have the right, at any time, to inspect and audit any records or documents of the Contractor or its subcontractors, and, at any time, to inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later.

### The Secretary, the U.S. Department of Health and Human Services, EOHHS, the Governor of the Commonwealth of Massachusetts, or the State Auditor, or any of their designees, may inspect and audit any books or records of the Contractor or its subcontractors pertaining to:

#### The Contractor’s ability to bear the risk of potential financial losses; or

#### The services performed or determination of amounts payable amounts under this Contract.

## Termination of Contract

### Termination without Prior Notice

In the event the Contractor fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, EOHHS may take any or all action under this Contract, law, or equity. Without limiting the above, if EOHHS determine that the continued participation of the Contractor in the Medicare or MassHealth program may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or MassHealth program, EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity.

### Termination with Prior Notice

Any party may terminate this Contract without cause upon no less than 180 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. If EOHHS is the terminating party, and the termination is pursuant to EOHHS’s authority under 42 CFR 438.708, such notice must include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1).

### Continued Obligations of the Parties

#### In the event of termination, expiration, or non-renewal of this Contract, or if the Contactor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

#### In the event that this Contract is terminated, expires, or is not renewed for any reason:

##### If EOHHS, or both, elect to terminate or not renew the Contract, EOHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;

##### The Contractor must promptly return to EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

##### The Contractor must supply to EOHHS all information necessary for the payment of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

### Termination Pursuant to 42 CFR 438.708; Pre-Termination Hearing

In accordance with 42 CFR 438.710 (b), EOHHS will provide the Contractor with a pre-termination hearing, if the reason for the termination of the Contract is because the Contractor either: a) failed to carry out the substantive terms of its contract or b) failed to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Medicaid Act.

#### EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708.

#### If EOHHS terminates this Contract pursuant to its authority under 42 CFR 438.708, EOHHS shall provide the Contractor with a pre-termination hearing in accordance with 42 CFR 438.710 as follows:

##### EOHHS shall give the Contractor written notice of intent to terminate, the reason for termination, and the time and place of the hearing;

##### After the hearing, EOHHS shall give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

##### If the decision is affirmed, EOHHS shall give Enrollees notice of the termination and information on their options for receiving MassHealth services following the effective date of termination in accordance with 42 CFR 438.710(b)(2)(iii) and Section 5.7.C.2.a. of this Contract.

#### If EOHHS terminates this Contract, EOHHS and the Contractor shall comply with all Continuing Obligations set forth in Section 5.7.C of this Contract.

## Order of Precedence

### The following documents are incorporated into and made a part of this Contract:

#### Appendices A through I to this Contract; and

#### Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.

### In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

#### The Contract terms and conditions;

#### Appendices A through I to this Contract; and

#### Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.

## Contract Term

This Contract shall be in effect for a period of five years, from January 1, 2016 through December 31, 2020. At the option of EOHHS, the Contract may be extended for up to five additional one year terms. EOHHS may exercise its extension option by providing written notice to the Contractor of its intent to do so at least sixty days prior to the expiration of the Contract term. The extension shall be under the same terms and conditions as the initial terms.

## Amendments

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

## Service Area Expansions

In calendar years 2019 and 2020, the Contractor may submit a written request to EOHHS to expand the Contractor’s Service Area to include all or part of Nantucket, Dukes, and/or Berkshire Counties. The Contractor shall provide to EOHHS any information requested by EOHHS in the course of its review of the Contractor’s requested Service Area expansion. EOHHS may, in its sole discretion, grant in full, grant in part, or reject the Contractor’s requested Service Area expansion. In the event that EOHHS grants the Contractor’s requested Service Area expansion, whether in full or in part, the Parties shall amend **Appendix H** accordingly.

## Written Notices

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

**To EOHHS**:

Elizabeth Goodman, Director

MassHealth Office of Long Term Services and Supports

One Ashburton Place, 5th floor

Boston, MA 02108

**With copies to**:

General Counsel

Executive Office of Health and Human Services

One Ashburton Place, 11th floor

Boston, MA 02108

**To the Contractor:**