COMMONWEALTH OF MASSACHUSETTS | **STANDARD CONTRACT FORM**

This form is jointly issued and published by the Office of the Comptroller, the Executive Office for Administration and Finance, and the Operational Services Division as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the Standard Contract Form Instructions and Contractor Certifications, the Commonwealth Terms and Conditions, the Commonwealth Terms and Conditions for Human and Social Services or the Commonwealth IT Terms and Conditions which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access forms at macomptroller.org/forms or mass.gov/lists/osd-forms.

CONTRACTOR INFORMATION

Contractor Legal Name: Commonwealth Care Alliance, Inc.	d/b/a:
Legal Address (As entered on Form W-9 or Form W-4): 30 Winter Street, Boston, MA 02108	
Contract Manager Name: Heather Friedmann	
Phone: (857)246-8825	Email: Hfriedmann@commonwealthcare.org
Fax: 617-426-3097	
Vendor Code: VC 6000306320	
Vendor Code Address ID: AD 001 (e.g. "AD001". Note: The Address ID must be set up for Electronic Funds Transfer (EFT) payments.)	

COMMONWEALTH INFORMATION

Department: Executive Office of Health and Human Services	MMARS Code: EHS
Contract Manager Name: Daniel Cohen	Business Mailing Address: One Ashburton Place, 10th Fl, Boston, MA 02108
Billing Address (If Different):	
Phone: 617-573-1710	Email: daniel.cohen@mass.gov
Fax:	
MMARS Doc ID(s):	
RFR/Procurement or Other ID Number: 23EHSKAONECARESCOPROCURE	

(•) NEW CONTRACT ( ) CONTRACT AMENDMENT

Procurement or Exception Type (Check one option only)

- [ ] **Statewide Contract** (OSD or an OSD-designated department.)
- [ ] **Collective Purchase** (Attach OSD approval, scope, and budget.)
- [x] **Department Procurement** - Includes all Grants 815 CMR 2.00. (Attach Solicitation Notice or RFR, and Response or other procurement supporting documentation.)
- [ ] **Emergency Contract** (Attach justification for emergency, scope, and budget.)
- [ ] **Contract Employee** (Attach Employee Status Form, scope, and budget.)
- [ ] **Interim Contract with new Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- [ ] **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope, and budget.)

Current Contract End Date *PRIOR* to Amendment	Amendment Amount Or Enter "No Change"

Amendment Type (Check one option only. Attach details of amendment changes.)

- [ ] **Amendment to Date, Scope, or Budget** (Attach updated scope and budget.)
- [ ] **Interim Contract with Current Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- [ ] **Contract Employee** (Attach any updates to scope or budget.)
- [ ] **Other Procurement Exception** (Attach authorizing language/justification and updated scope/budget.)

TERMS AND CONDITIONS

The Standard Contract Form Instructions and Contractor Certifications and the following document are incorporated by reference into this Contract and are legally binding (Check ONE option):
(•) Commonwealth Terms and Conditions ( ) Commonwealth Terms and Conditions for Human and Social Services ( ) Commonwealth IT Terms and Conditions

COMPENSATION (Check ONE option.)

The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.
(•) Rate Contract (No Maximum Obligation). (Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)
( ) Maximum Obligation Contract. Total maximum obligation for total duration of this contract (or new total if contract is being amended):

PROMPT PAYMENT DISCOUNTS (PPD)

Commonwealth payments are issued through Electronic Funds Transfer (EFT) 45 days from invoice receipt. See Prompt Pay Discounts Policy.

Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within: 10 days % PPD. 15 days % PPD. 20 days % PPD. 30 days % PPD.

If PPD percentages are left blank, identify reason:
[ ] Statutory/legal [ ] Ready Payments (M.G.L. c. 29, § 23A) [x] Agree to standard 45-day cycle [ ] Only initial payment

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT

Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.

MassHealth is contracting with Commonwealth Care Alliance, Inc. for its Senior Care Options plan, to provide Covered Services to the populations defined herein under the terms defined herein.

SUPPLIER DIVERSITY PROGRAM (SDP) PLAN

Does the Supplier Diversity Program apply? ( ) YES If YES, the Contractor's annual SDP commitment for this Contract is
(•) NO If NO, and the department is an Executive Department, enter the appropriate exemption: Insurance.

ANTICIPATED START DATE (Complete ONE option only.)

The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:
(•) 1. may be incurred as of the Effective Date (latest signature date below) and no obligations have been incurred prior to the Effective Date.
( ) 2. may be incurred as of , 20 , a date LATER than the Effective Date below and no obligations have been incurred prior to the Effective Date.
( ) 3. were incurred as of , 20 , a date PRIOR to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE

Contract performance shall terminate as of December 31 , 20 30 , with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS

Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR (Signature and date must be captured at time of signature.)		AUTHORIZING SIGNATURE FOR THE COMMONWEALTH (Signature and date must be captured at time of signature.)	
Signature: Sanjoy Musunuri	Date: 6-16-25	Signature: Mike Levine	Date: 06/17/2025
Print Name: Sanjoy Musunuri	Print Title: Chief Executive Officer, Commonwealth Care Alliance	Print Name: Mike Levine	Print Title: Assistant Secretary for MassHealth

MASSHEALTH SENIOR CARE OPTIONS (SCO)

CONTRACT

FOR SENIOR CARE OPTIONS PLANS

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

Commonwealth Care Alliance, Inc.

This Contract is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS") and Commonwealth Care Alliance, Inc. The Contractor's principal place of business is: 30 Winter Street, Boston, MA 02108.

WHEREAS, EOHHS oversees 11 state agencies and is the single state agency responsible for the administration of the Medicaid program and the State Children's Health Insurance Program within Massachusetts (collectively, MassHealth) and other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E, Title XIX of the Social Security Act (42 U.S.C. sec. 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. sec. 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS issued a Request for Responses (RFR) for Senior Care Options (SCO) Plans on November 30, 2023, to solicit responses from SCO Plans to provide comprehensive health care coverage to eligible MassHealth Members; and

WHEREAS, EOHHS has selected the Contractor, based on the Contractor's response to the RFR, submitted by the deadline for responses, to provide health care coverage to eligible MassHealth Members in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations; and

WHEREAS, EOHHS and the Contractor agree that the terms stated herein are subject to all required approvals of the federal Centers for Medicare and Medicaid Services (CMS), and

WHEREAS, EOHHS and the Contractor entered into this Contract effective upon execution;

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

Table of Contents

1 DEFINITION OF TERMS 6

2 CONTRACTOR RESPONSIBILITIES 28

2.1. COMPLIANCE 28

2.2. CONTRACT READINESS 29

2.3. ADMINISTRATION AND CONTRACT MANAGEMENT 33

2.4. ELIGIBILITY, ENROLLMENT, AND INITIAL OUTREACH 69

2.5. ASSESSMENTS AND CARE PLANS 83

2.6. CARE COORDINATION AND CARE MODEL 96

2.7. COVERED SERVICES AND CARE DELIVERY 117

2.8. PROVIDER NETWORK, CONTRACTS, AND RELATED RESPONSIBILITIES 134

2.9. NETWORK MANAGEMENT 158

2.10. ENROLLEE ACCESS TO SERVICES 184

2.11. ENROLLEE SERVICES 214

2.12. MARKETING, OUTREACH, AND ENROLLEE COMMUNICATION STANDARDS 218

2.13. GRIEVANCES AND APPEALS 233

2.14. QUALITY MANAGEMENT 256

2.15. DATA MANAGEMENT, INFORMATION SYSTEMS REQUIREMENTS, AND REPORTING REQUIREMENTS 274

2.16. FINANCIAL STABILITY REQUIREMENTS 299

2.17. BENEFIT COORDINATION 307

3 EOHHS RESPONSIBILITIES 312

3.1. CONTRACT MANAGEMENT 312

3.2. ENROLLMENT AND DISENROLLMENT SYSTEMS 315

3.3. OUTREACH, MARKETING, AND EDUCATION MONITORING 315

4 PAYMENT AND FINANCIAL PROVISIONS 316
4.1. SCO RATING CATEGORIES AND ASSIGNMENT 316
4.2. PAYMENT METHODOLOGY AND TERMS 319
4.3. TRANSITIONS BETWEEN RATING CATEGORIES 323
4.4. RECONCILIATION 324
4.5. RISK CORRIDORS 326
4.6. PAYMENT IN FULL 334
4.7. PERFORMANCE INCENTIVE ARRANGEMENTS AND WITHHOLDS 334
5 ADDITIONAL TERMS AND CONDITIONS 338
5.1. ADMINISTRATION 338
5.2. CONFIDENTIALITY 346
5.3. GENERAL TERMS AND CONDITIONS 348
5.4. RECORD RETENTION, INSPECTION, AND AUDIT 355
5.5. TERMINATION OF CONTRACT 359
5.6. ORDER OF PRECEDENCE 359
5.7. CONTRACT TERM 362
5.8. AMENDMENTS 362
5.9. WRITTEN NOTICES 363
APPENDICES
APPENDIX A PROGRAMMATIC REPORTING REQUIREMENTS
APPENDIX B PERFORMANCE IMPROVEMENT GOALS
APPENDIX C COVERED SERVICES, DEFINITIONS
EXHIBIT 1 GENERAL SERVICES
EXHIBIT 2 BEHAVIORAL HEALTH SERVICES
EXHIBIT 3 ADDITIONAL COMMUNITY-BASED SERVICES

APPENDIX D PAYMENT

EXHIBIT 1 BASE CAPITATION RATES

EXHIBIT 2 DIRECTED PAYMENTS

APPENDIX E RISK SHARING ARRANGEMENTS

APPENDIX F PLAN SPECIFIC APPROVALS

EXHIBIT 1 SERVICE AREA

EXHIBIT 2 PBP ELIGIBILITY CRITERIA

APPENDIX G BEHAVIORAL HEALTH SERVICES

EXHIBIT 1 COMMUNITY BEHAVIORAL HEALTH CENTER (CBHC) LIST

EXHIBIT 2 STATE OPERATED COMMUNITY MENTAL HEALTH CENTERS (SOCMHCS)

EXHIBIT 3 STATE OPERATED FACILITIES PROVIDING INPATIENT MENTAL HEALTH SERVICES, OUTPATIENT BEHAVIORAL HEALTH SERVICES, AND DIVERSIONARY BEHAVIORAL HEALTH SERVICES

EXHIBIT 4 STATE-OWNED DMH AND DPH HOSPITALS

EXHIBIT 5 DMH BULLETIN #19-01 (MARCH 1, 2019)

EXHIBIT 6 RESERVED

APPENDIX H ENCOUNTER DATA AND MEMBER DATA SPECIFICATIONS

EXHIBIT 1 DATA SPECIFICATIONS COVER

EXHIBIT 2 ENCOUNTER DATA SET REQUEST

EXHIBIT 3 MEMBER DATA SPECIFICATIONS

APPENDIX I CREDENTIALING WEBSITES AND TIBCO

APPENDIX J MMIS INTERFACES

APPENDIX K MATERIAL SUBCONTRACTOR CHECKLIST

APPENDIX L QUALITY IMPROVEMENT AND PROJECT REQUIREMENTS

APPENDIX M DISCRETIONARY INVOLUNTARY DISENROLLMENT REQUESTS FOR DISRUPTIVE CONDUCT

APPENDIX N ENROLLEE RIGHTS

APPENDIX O CONTRACTOR INFORMATION

APPENDIX P DENTAL ACCESS

APPENDIX Q POPS BATCH INTERFACES

APPENDIX R ACCEPTABLE ADMITTED ASSETS

APPENDIX S FRAIL ELDER WAIVER

APPENDIX T MDS-HC 2.0 SUPPLEMENTAL INSTRUCTIONS

1 Definition of Terms

1.1. **1915(c) Waivers or Home and Community-based Services Waivers (HCBS Waivers)** – A federally approved program operated under Section 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility operated by the Department of Developmental Services (DDS).

1.2. **Abuse** - Actions or inactions by Providers (including the Contractor) and/or Members that are inconsistent with sound fiscal, business or medical practices, and that result in unnecessary cost to the MassHealth program, including, but not limited to practices that result in MassHealth reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care.

1.3. **Activities of Daily Living (ADLs)** – Certain basic tasks required for daily living, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed/chair, get around inside the home, and manage incontinence.

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

1.5. **Actual Medical Expenditures** — The Contractor's actual amount paid for Covered Services (as referenced in **Section 2.7** and defined in **Appendix C**) delivered. Actual Medical Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk sharing arrangements, and sub-capitation payments.

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

1.7. **Adult Mobile Crisis Intervention (AMCI)** (formerly known as Emergency Services Program (ESP)) - AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization, and follow-up for up to three (3) days. AMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences) and provided via Telehealth to individuals age 21 and older when requested by the Member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operate Adult CCS programs with a preference for co-location of services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

1.8. **Advance Directive** – A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

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

1.9.1. The failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.7**;

1.9.2. The denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;

1.9.3. The reduction, suspension, or termination of a previously authorized service;

1.9.4. 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:

1.9.4.1. Failure to follow prior authorization procedures;

1.9.4.2. Failure to follow referral rules;

1.9.4.3. Failure to file a timely claim;

1.9.4.4. The failure to act within the timeframes in **Section 2.10.9.8** for making authorization decisions;

1.9.4.5. The denial of an Enrollee’s request to dispute a financial liability;

1.9.4.6. The failure to act within the timeframes in Section **2.13.4.4** for reviewing an Internal Appeal and issuing a decision; and

1.9.4.7. an adverse decision on an Integrated Organization Determination (as defined in 42 CFR § 422.561), to the extent not otherwise included in items (1)-(7).

1.10. **Aging Services Access Point (ASAP)** - An entity organized under Massachusetts General Law (M.G.L.) c.19A §4B that contracts with the Executive Office of Aging & Independence (AGE) to manage the Home Care Program in Massachusetts and that performs case management, screening, and authorization activities for certain long-term care services.

1.11. **Alternative Formats** – Formats for the provision of Enrollee information that enhance accessibility. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, American Sign Language video clips, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.

1.12. **Alternative Payment Methodologies** - Methods of payment, not based on traditional Fee-For-Service methodologies, that compensate providers for the provision of health care or support services and tie payments to quality of care and outcomes. These include, but are not limited to, shared savings and shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and global payments. Payments based on traditional Fee-For-Service methodologies shall not be considered Alternative Payment Methodologies.

1.13. **American Sign Language (ASL) Interpreters** - A specially trained professional whose job is to translate between people who do not share the same language or mode of communication. The purpose of providing an interpreter is to allow hearing, deaf and hard of hearing individuals equal access to information and interactions.

1.14. **Appeal** – An Enrollee's request for formal review of an Adverse Action of the Contractor in accordance with **Section 2.13**.

1.15. **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 shall allow an Enrollee to give a standing authorization to an Appeal Representative to act on their 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.

1.16. **Appeals Coordinator** - A staff person designated by the Contractor to act as a liaison between the Contractor and the Board of Hearings.

1.17. **ASAM** – The American Society for Addiction Medicine, a professional society in the field of addiction medicine that sets standards, guidelines, and

performance measures for the delivery of addiction treatment which includes a continuum of five basic levels of care from Level 0.5 (early intervention) to Level 4.0 (medically managed intensive inpatient treatment). References to levels within the Contract with respect to Behavioral Health services are references to these ASAM levels.

1.18. **Authorized Representative** – A friend, family member, relative, or other person chosen by a Member to help with some or all of the responsibilities of applying for or getting MassHealth benefits. This may include enrolling in and receiving services from a SCO Plan. An Authorized Representative may fill out an application or review form and other MassHealth eligibility forms, give MassHealth proof of information given on applications, review forms, and other MassHealth forms, reports changes in a Member's income, address, or other circumstances, and get copies of all MassHealth eligibility notices sent to the Member.

1.19. **Base 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, prior to the application of any risk adjustment.

1.20. **Behavioral Health** – The promotion of emotional health, the prevention of mental illnesses and substance use disorders, and the provision of treatments and services for mental and/or substance use disorders.

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

1.22. **Behavioral Health Services** - Covered Services as set forth in detail in Appendix C, as applicable, of this Contract, that promote emotional health, prevent mental illnesses and substance use disorders, and treat mental health and/or substance use disorders.

1.23. **Behavioral Health Urgent Care** – the delivery of same-day or next-day appointments for evaluation or assessment for new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) within a timeframe defined by EOHHS; all other treatment appointments within fourteen (14) calendar days; and extended availability outside of weekday hours between 9:00 am and 5:00 pm, as specified by EOHHS by certain Mental Health Centers (MHC), approved by the Contractor as Behavioral Health Urgent Care Providers, as specified by EOHHS.

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

1.25. **Board of Hearings (BOH)** - The Board of Hearings within the EOHHS.

1.26. **BOH Appeal** - A written request to the BOH, made by an Enrollee or Appeal Representative to review the correctness of a Final Internal Appeal decision by the Contractor.

1.27. **Bureau of Special Investigations (BSI)** - A bureau within the Office of the State Auditor that is charged with the responsibility of investigating Member fraud within the Commonwealth's public assistance programs, principally those administered by the Department of Transitional Assistance (DTA) and the EOHHS Office of Medicaid.

1.28. **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.

1.29. **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 2.15.5.6** for more information about the contents of the Centralized Enrollee Record.

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

1.31. **Chronically Homeless** or **Chronic Homelessness** - A definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for twelve (12) months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter, or safe haven) over a three (3) year period where the combined occasions must total at least twelve (12) months (occasions must be separated by a break of at least seven nights, stays in institution of fewer than ninety (90) days do not constitute a break). To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious and persistent mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical

illness, or disability, including the co-occurrence of two or more of those conditions.

1.32. **Claim** - A Provider's bill for services, performed per Enrollee, by line item, including but not limited to services performed, units of service, and billing charges.

1.33. **Claim Attachment** - A supplemental document submitted in conjunction with a Claim that provides additional information that concurs with the services billed.

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

1.35. **Clinical Criteria** - Criteria used to determine the most clinically appropriate and necessary level of care (LOC) and intensity of services to ensure the provision of Medically Necessary Services.

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

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

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses and community centers;
- Bridging and/or culturally mediating between Enrollees, communities, and health and human services, including actively building individual and community capacity;
- Assisting Enrollees to access the services and community resources they need;

- Providing direct services, such as informal counseling, social support, care coordination and health screenings;
- Advocating for individual and community needs; and
- Assisting Enrollees to engage in wellness activities as well as chronic disease self-management.

CHWs are distinct from other health professionals because they are hired primarily for their understanding of the populations and communities they serve, spend a significant portion of time conducting outreach in the categories above, and have experience providing services in community settings.

The Massachusetts Department of Public Health (DPH) has established criteria and training for individuals to become Certified Community Health Workers.

1.38. **Complex Care** – Care and care coordination for an Enrollee who is unable to independently perform, without human assistance or cueing, two or more activities of daily living or who is determined to be in need of continuous behavioral health or social services to maintain minimal daily independent functioning. Such care shall address Enrollee needs, including any condition or situation that requires coordination of multiple services. Enrollees requiring Complex Care are minimally those individuals who meet any of the criteria below, the Contractor shall not limit such designation by an Enrollee's assignment to a Rating Category:

1.38.1. Have LTSS and BH co-occurring conditions/needs, or needs in two (2) or more domains (i.e., physical, BH, functional, cognitive, and social);

1.38.2. Have co-morbidities;

1.38.3. Have complex or high-risk presentations of a condition, functional limitation, or disease;

1.38.4. Have rare diseases that require additional specialized Care Coordination; or

1.38.5. Require highly individualized approaches to care and/or intense care management to prevent complications or increased severity of symptoms or conditions.

1.39. **Comprehensive Assessment** - A person-centered process used by the Contractor during at least one in-person meeting to document an Enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.5** of this contract.

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

1.41. **Continuing Services** — Covered Services that were previously authorized by the Contractor and are the subject of an internal Appeal or Board of Hearings (BOH) Appeal, if applicable, involving a decision by the Contractor to terminate, suspend, or reduce the previous authorization and which are provided by the Contractor pending the resolution of the internal Appeal or BOH Appeal, if applicable. Continuing Services (also referred to as continuation of benefits per §422.632) include previously approved Medicare and/or Medicaid benefit(s) that the plan is terminating, suspending, or reducing.

1.42. **Contract** — The Contract between EOHHS and the Contractor awarded pursuant to EOHHS's Request for Response (RFR).

1.43. **Contract Effective Date** – The date on which a Contract resulting from this procurement is effective, which shall be the date of Contract execution.

1.44. **Contract Management Team** - A group of EOHHS representatives responsible for overseeing the contract management functions outlined in **Section 2.3** of the Contract.

1.45. **Contract Operational Start Date** - The date on which a Contractor first provides Covered Services through a SCO Plan, which shall be January 1, 2026.

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

1.47. **Contractor** — Any entity that enters into an agreement with EOHHS for the provision of services described in the Contract.

1.48. **Covered Services** - Those services referenced in **Section 2.7** of the contract and defined in **Appendix C**. 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).

1.49. **Critical Incident** - As further defined in Managed Care Entity Bulletin 111 (or a successor bulletin), any sudden or progressive development (event) that requires immediate attention and decisive action to prevent or minimize any negative impact on the health and welfare of one or more MassHealth Members.

1.50. **Cultural and Linguistic Competence** – Competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Services.

1.51. **Cultural Competence** – Understanding those values, beliefs, and needs that are associated with an Enrollee's age, gender, gender identity, sexual orientation, or with their racial, ethnic, or religious background. Cultural

Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

1.52. **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

1.53. **Deemed Eligibility** — The determination to continue to provide Medicare coverage for an individual who no longer meets the State eligibility criteria for enrollment into a SCO Plan, as long as the individual can reasonably be expected to regain SCO eligibility in accordance with the State criteria within a specified period of time.

1.54. **Default Enrollment** - An enrollment process that allows a Medicare Advantage organization (MAO), following approval by the state and CMS, to enroll a MassHealth Member enrolled in an affiliated Medicaid MCO (i.e., MassHealth health plan) into its Medicare Dual Eligible Special Needs Plan (D-SNP) when that Member becomes newly eligible for Medicare (Parts A and B) – unless the Member chooses otherwise. This process is only permissible in circumstances where the Member enrolls with the SCO plan offered by their MassHealth health plan upon receiving Medicare eligibility. The Default Enrollment effective date shall always be the date of the individual's first entitlement to both Medicare Part A and Part B.

1.55. **Department of Mental Health (DMH) Community-based Services** – DMH non-acute mental health care services provided to DMH clients, such as ACCS, community aftercare, housing and support services, and non-acute residential services.

1.56. **Discharge Planning** - The evaluation of an Enrollee's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care and living situation after discharge from one care setting (e.g., acute hospital, inpatient behavioral health facility) to another care setting (e.g., rehabilitation hospital, group home), including referral to and coordination of appropriate services.

1.57. **Dual Eligible** – For purposes of this document, an adult age 65 or older who is eligible for and enrolled in Medicare Parts A and B and enrolled in MassHealth Standard coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus) and Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) age 65 or older and with MassHealth Standard coverage.

1.58. **Effective Enrollment Date -** The first calendar day of the month following the receipt of Enrollee's enrollment into a SCO plan.

1.59. **Eligibility Redetermination** – The process by which MassHealth Members must complete certain forms and provide certain verifications in order to establish continued MassHealth eligibility. This process is required annually, or in response to certain changes in the Member's circumstances.

1.60. **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.

1.61. **Eligible Individual** - A person age 65 or older who is enrolled in Medicare Parts A and B and eligible for MassHealth Standard and no other comprehensive private or public health coverage, and who otherwise meets the participation criteria in **Section 2.4.1**. For purposes of this Contract, a person is considered eligible on the first of the month in which they turn 65 and are eligible for Medicare Parts A and B.

1.62. **Emergency Medical Condition** - A medical condition, whether physical or mental, that manifests itself by acute symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: one (1) placing the health of the individual (or with respect to a pregnant individual, the health of the pregnant individual or their unborn child) in serious jeopardy, two (2) serious impairment to bodily functions, or three (3) serious dysfunction of any bodily organ or part.

1.63. **Emergency Services** — Covered inpatient and outpatient services, including Behavioral Health Services, which are furnished to an Enrollee by a Provider that is qualified to furnish such services under 42 C.F.R. §438.206(c)(1)(iii) and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

1.64. **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 H**.

1.65. **Enrollee** - A Member enrolled in the Contractor's Plan. A Member shall be considered an Enrollee beginning on the Effective Date of Enrollment in the Contractor's Plan, including retroactive enrollment periods. A Member shall not be considered an Enrollee during any period following the Effective Date of Disenrollment from the Contractor's Plan, including retroactive disenrollment periods. An Enrollee also includes an individual who remains enrolled during a deeming period.

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

1.67. **Enrollee Information** - Information about the Contractor for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.8.7** and a Member Handbook that meets the requirements of **Section 2.12.5**, and an identification card.

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

1.69. **Executive Office of Aging & Independence (AGE)** - 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.

1.70. **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, Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

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

1.72. **Fee-For-Service (FFS)** – A method of paying an established fee for a unit of health care service.

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

1.74. **Flexible Benefits** - Items or services other than – or beyond the amount, duration, and scope of – Covered Services (defined in **Section 1** and listed in **Appendix C**). As described in 42 CFR 438.3(e)(1)(i), the Contractor may provide such items or services as specified in the Enrollee's Individualized Care Plan and appropriate to address the Enrollee's needs. The cost of such items shall not be considered in determining MassHealth capitation rates.

1.75. **Frail Elder Home and Community-based Services Waiver (Frail Elder Waiver or FEW)** - 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 EOHHS to pay for home and community-based

services for certain MassHealth Members who meet MassHealth criteria for Nursing Facility services but continue to reside in the community and agree to receive a waiver service. The term “Frail Elder Waiver” as used in this contract shall refer to the content of the waiver, as may be updated from time to time as approved by CMS.

1.76. **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 the person, the corporation, or some other person or entity. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include 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 improperly obtaining prescriptions for controlled substances and card sharing.

1.77. **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)** - A managed care plan defined at 42 CFR 422.2 as a Dual Eligible Special Needs Plan:

1.77.1. That provides Dual Eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under Section 1903(m) of the Act with the applicable State;

1.77.2. Whose capitated contract with the State Medicaid agency requires coverage, consistent with State policy, of specified primary care, acute care, Medicaid coverage of Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries; behavioral health services; and Long-term Services and Supports, including coverage of nursing facility services for a period of at least 180 days during the plan year; home health services as defined in 42 CFR § 440.70, and medical supplies, equipment, and appliances as described in 42 CFR § 440.70(b)(3);

1.77.3. That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries;

1.77.4. That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement;

1.77.5. That has exclusively aligned enrollment; and

1.77.6. Whose capitated contract with the State Medicaid agency covers the entire service area for the Dual Eligible Special Needs Plan.

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

1.79. Reserved

1.80. **Geriatric Support Services Coordinator (GSSC)** - A member of a SCO care team who is employed by an Aging Services Access Point (ASAP), is qualified to conduct and is responsible for arranging, coordinating, and authorizing the provision of appropriate community long-term care and social support services.

1.81. **Grievance** –Any complaint or dispute, other than one that constitutes an Integrated Organization Determination, expressing dissatisfaction with any aspect of the Contractor or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

1.81.1. A grievance may be submitted by an Enrollee or an Enrollee's 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 regardless of whether remedial action is requested. Grievances include an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision. For the purposes of this Contract grievances follow the rules of integrated grievances as defined in 42 CFR § 422.561. Grievance may also be referred to as complaint.

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

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

1.84. **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.

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

1.86. **Indian Enrollee** – An individual who is an Indian (as defined in Section 4.2.8 of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) and is enrolled in the Contractor's SCO plan.

1.87. **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.

1.88. **Individualized Care Plan (ICP) -** The plan of care developed by an Enrollee and an Enrollee's Interdisciplinary Care Team. The plan of care outlines the scope, frequency, type, amount, and duration, of all Covered Services to be provided by the Contractor to the Enrollee as described in **Section 2.7** of this Contract.

1.89. **Instrumental Activities of Daily Living (IADLs)** – Certain basic environmental tasks required for daily living, including the ability to prepare meals, do housework, laundry, and shopping, get around outside, use transportation, manage money, perform care and maintenance of wheelchairs and adaptive devices, and use the telephone.

1.90. **Interdisciplinary Care Team (ICT) -** A team consisting of at least the Enrollee's PCP and a GSSC and/or Registered Nurse conducting required assessments, the care team is responsible for effective coordination and delivery of care for SCO Enrollees. The team is responsible for working with the Enrollee to develop, implement, and maintain their care plan. In SCO, this may also be referred to as the Primary Care Team (PCT).

1.91. **Justice Involvement -** Enrollees with Justice Involvement include those individuals released from a correctional institution within one (1) year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.

1.92. **Key Personnel** – Staff within the Contractor's organization accountable for significant areas of the organization, or who have responsibility for the implementation and operation of major programmatic and administrative functions.

1.93. **Long-term Services and Supports (LTSS)** – A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are

provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

1.94. **Marketing, Outreach, and Enrollee Communications** - 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.

1.95. **MassHealth** - The Massachusetts Medicaid Program, 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).

1.96. **MassHealth CommonHealth** – MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain working and non-working disabled adults.

1.97. **MassHealth Standard** - MassHealth coverage type that offers a full range of health benefits to certain Eligible Individuals, including families, pregnant individuals, individuals with disabilities under age 65, and individuals age 65 and older. For purposes of this Contract, MassHealth Standard Members means individuals age 21 and older.

1.98. **Material Subcontractor** – Any entity from which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its Administrative Services for any program area or function that relates to the delivery or payment of Covered Services or Flexible Benefits, including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management, or pharmacy benefits, including specialty pharmacy providers. Contracts with Material Subcontractors shall be referred to as Material Subcontracts. Material Subcontracts are distinct from Provider Contracts.

1.99. **Medicaid** — The program of medical assistance benefits under Title XIX of the Social Security Act.

1.100. **Medicaid Fraud Division (MFD)** – A division of the Massachusetts Office of the Attorney General that is dedicated to investigating cases of suspected Fraud or Abuse.

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

1.102. **Medicaid Waiver** - Generally, a waiver of existing law authorized under Section 1115(a), or 1915 of the Social Security Act.

1.103. **Medically Necessary or Medical Necessity** – Services shall be provided consistent with all Enrollee protections and benefits provided by Medicare and MassHealth, and that provide the Enrollee with coverage to at least the same extent, and with the cumulative effect, as provided by the combination of Medicare and MassHealth.

1.103.1. Per Medicare, Medically Necessary Services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body Member, or otherwise medically necessary under 42 U.S.C. § 1395y.

1.103.2. In accordance with Medicaid law and regulations, services shall be provided in accordance with MassHealth regulations, including in accordance with 130 CMR 450.204. Medically Necessary services are those services:

1.103.2.1. That 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

1.103.2.2. 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.

1.103.2.3. Medically Necessary services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

1.103.3. In addition, a service is Medically Necessary when:

1.103.3.1. It may attain, maintain, regain, improve, extend, or expand the Enrollee's health, function, functional capacity, overall capacity, or otherwise support the Enrollee's ability to do so; or

1.103.3.2. A delay, inaction, or a reduction in amount, duration, or scope, or type or frequency of a service may jeopardize the Enrollee's health, life, function, functional capacity, or overall capacity to maintain or improve health or function.

1.104. **Medicare** - Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities (SNFs) and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health

care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

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

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

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

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

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

1.110. **Ombudsman** — A neutral entity that has been contracted by MassHealth to assist Enrollees and any other MassHealth Members (including their families, caregivers, representatives, and/or advocates) with information, issues, or concerns related to SCO or other MassHealth health plans, benefits or services (may also be referred to as My Ombudsman). Ombudsman staff fulfill both individual and systemic advocacy roles.

1.111. **One Care** - A comprehensive managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare - and Medicaid-covered benefits for MassHealth Members eligible for both programs. Services are developed and delivered based on an Enrollee's person-centered assessment and care plan.

1.112. **Person Centered** - Person-centered care and person-centered planning in SCO means providing Covered Services, Flexible Benefits, and coordination to an Enrollee to meet the individual's needs and goals. Placed at the center of care and planning, the Enrollee and their needs, preferences, and goals provide direction and purpose for what and how medical, behavioral health, Long-term Services and Supports, and Flexible Benefits are provided, including to address Social Determinants of Health and health equity. This is achieved by integrating

available resources of the MassHealth and Medicare programs as defined in the Contract.

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

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

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

1.116. **Post-stabilization Care Services** – Covered Services, related to an Emergency Medical Condition, whether physical or mental, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or, when covered pursuant to 42 CFR 438.114(e), to improve or resolve the Enrollee's condition.

1.117. **Prevalent Languages** – English, Spanish, and any languages spoken by five percent (5%) or more of Enrollees in the Plan's Service Area. EOHHS may identify additional or different languages spoken by a significant percentage of Enrollees as Prevalent Languages at any time during the term of the Contract.

1.118. **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.

1.119. **Primary Care Provider (PCP)** - The individual practitioner or team selected by the Enrollee, or assigned to the Enrollee by the Contractor, to provide and coordinate all of the Enrollee's health care needs and to initiate and monitor referrals for specialty services when required. PCPs include nurse practitioners practicing in collaboration with a physician under Massachusetts General Laws Chapter 112, Section 80B and its implementing regulations or physicians who are board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, Geriatrics, or Obstetrics/Gynecology. PCPs for persons with disabilities, including but not

limited to, persons with HIV/AIDS, may include practitioners who are board certified or eligible for certification in other relevant specialties. PCPs also include registered nurses or advanced practice nurses, who are licensed by the commonwealth and certified by a nationally recognized accrediting body, and physician assistants who are licensed by the Board of Registration of Physician Assistants. All PCPs must be in good standing with the federal Medicare and Federal/State Medicaid (MassHealth) program.

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

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

1.122. **Provider** – An individual, group, facility, agency, Institution, organization, or business that furnishes or has furnished medical services to Enrollees.

1.123. **Provider Contract** – An agreement between the Contractor and a Provider for the provision of services.

1.124. **Provider Network** - The collective group of Network Providers, including but not limited to PCPs, physicians, nurses, nurse practitioners, physician assistants, specialty Providers, mental health/substance use disorder Providers, community and institutional long-term care Providers, pharmacy Providers, and acute hospital and other Providers employed by or under subcontract with the Contractor.

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

1.126. **Rating Category** – As described in **Section 4.1.2**, an identifier used by EOHHS to identify a specific grouping of Enrollees for which a discrete Base Capitation Rate applies pursuant to the Contract.

1.127. **Readiness Review** – Prior to being eligible to accept SCO Medicaid enrollments, each prospective Contractor selected to operate a SCO plan must undergo EOHHS’s Readiness Review. The Readiness Review evaluates each prospective Contractor’s ability to comply with the requirements specified in this Contract, including but not limited to, the ability to quickly and accurately process

claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. EOHHS will use the results to inform its decision of whether the prospective Contractor is ready to operate a SCO plan. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective Contractor's headquarters.

1.128. **Recovery Learning Community (RLC)** – Consumer-run networks of self-help/peer support, information and referral, advocacy and training activities. Training in recovery concepts and tools, advocacy forums and social and recreational events are all part of what goes on in a Recovery Learning Community.

1.129. **Request for Responses (RFR)** – The Request for Responses for SCO Plans issued by EOHHS and the RFR from which this Contract resulted.

1.130. **Risk Adjusted Capitation Rate** – The Base Capitation Rate as adjusted by the risk score to reflect acuity of the Enrollees in accordance with **Section 4.2.4** of the Contract (if applicable).

1.131. **SCO Advisory Committee** - A working committee that advises MassHealth regarding ongoing Senior Care Options (SCO) operations, as well as the appropriate outreach, enrollment, and disenrollment policies for Eligible persons.

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

1.133. **Senior Care Options (SCO)** - A managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for eligible Massachusetts individuals managed by a SCO Plan using a person-centered model of care.

1.134. **Senior Care Options (SCO) Plan** - The managed care plan operated by the Contractor pursuant to the terms of the Contract.

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

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

1.137. **Service Area** – A geographic area, specified by EOHHS and as listed in **Appendix F, Exhibit 1** of the Contract, in which a Contractor has contracted with EOHHS to serve MassHealth Members.

1.138. **Service Request** - An Enrollee's oral or written request of the Contractor to authorize and pay for a benefit or service. This request for services shall include Covered Services as referenced in **Section 2.7** and defined in **Appendix C**. Service Requests may also be referred to as: requests for Covered Services, requests for coverage decisions or requests for Integrated Organization Determinations.

1.139. **Social Determinant(s) of Health (SDoH)** – Condition(s) in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

1.140. **Solvency** - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by DOI.

1.141. **State** - The Commonwealth of Massachusetts.

1.142. **State Fair Hearing** - An Appeal filed for Medicaid services with the Board of Hearings.

1.143. **State Medicaid Agency Contract (SMAC)** - A set of requirements for all new and existing Medicare Advantage organizations seeking to offer a D-SNP.

1.144. **Surrogate** – An Enrollee's legal guardian, family Member, or other person who has been identified in the Service Agreement with the Personal Care Management (PCM) agency that will be responsible for performing certain personal care attendant (PCA) management tasks that the Enrollee is unable to perform. The Surrogate must live in proximity to the Enrollee and be readily available to perform the PCA management tasks.

1.145. **Third-Party Liability (TPL) Indicator Form** – Form supplied to inpatient hospitals by EOHHS that is used to notify the Contractor when the hospital discovers that an Enrollee has comprehensive insurance coverage other than Medicare or Medicaid.

1.146. **Urgent Care** - Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical 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 Medical Condition.

1.147. **Utilization Management** – A process of evaluating and determining coverage for and appropriateness of Covered Services as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources, which can be done on a prospective or retrospective basis, including service authorization and prior authorization.

1.148. **Waste** - Misuse of funds or resources through excessive or nonessential expenditures

2 Contractor Responsibilities

2.1. Compliance

2.1.1. The Contractor shall comply, to the satisfaction of EOHHS, with:

2.1.1.1. All provisions set forth in this Contract;

2.1.1.2. All applicable provisions of federal and State laws, regulations, guidance, waivers, including the implementation of a compliance plan;

2.1.1.3. Federal Medicaid Managed Care statutes and regulations, including all applicable provisions of 42 U.S.C. § 1396u-2 et seq. and 42 CFR 438 et seq. at all times during the term of this Contract;

2.1.1.4. Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423; and

2.1.1.5. All applicable bulletins issued by EOHHS.

2.1.2. Medicaid and Medicare Coordination and Integration

2.1.2.1. The Contractor shall employ policies and procedures approved by EOHHS to deliver and coordinate or integrate Medicare and Medicaid Covered Services, Member communication materials, enrollment, communications, Grievances and Appeals, Service Requests, Utilization Management, and quality improvement as further described in this Contract, including but not limited to **Sections 2.4**, **2.6**, **2.7, 2.10, 2.11, 2.12, 2.13,** and **2.14**, and **Appendix C**.

2.1.3. Conflict of Interest

2.1.3.1. Neither the Contractor nor any Material 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. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor has any financial, legal, contractual, or other business interest in any entity performing health plan enrollment functions for EOHHS, the EOHHS customer service vendor, and Material Subcontractor(s), if any.

2.1.3.2. In accordance with 42 U.S.C. § 1396u 2(d)(3) and 42 C.F.R. § 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 Material Subcontractors 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).

2.2. Contract Readiness

2.2.1. Readiness Review Overview

2.2.1.1. EOHHS or its designee shall conduct a Readiness Review of the Contractor to verify the Contractor's assurances that the Contractor is ready and able to perform satisfactorily in each of the areas set forth in 42 CFR 438.66(d)(4) and to meet its obligations under the Contract.

2.2.1.2. Readiness review shall be conducted prior to the Contractor accepting enrollment of eligible individuals into the Contractor's SCO Plan, including as described in **Section 2.2.4.4**.

2.2.1.3. At the request of EOHHS, the Contractor shall provide to EOHHS, or its designee:

2.2.1.3.1. Access to all information, materials, contracts, or documentation pertaining to the provision of any service or function required under this Contract within five (5) business days of receiving the request;

2.2.1.3.2. Access to all systems, facilities, sites, and locations at which one or more services or functions required under this Contract occurs or is provided.

2.2.1.4. EOHHS reserves the right to conduct additional readiness reviews, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives and/or Service Area expansions, as further specified by EOHHS.

2.2.2. Contract Readiness Workplan

2.2.2.1. As specified by EOHHS, the Contractor shall submit to EOHHS, for its review and approval, a workplan which shall be used by EOHHS to monitor the Contractor's progress toward achieving Contract readiness, as detailed in this **Section 2.2**, in accordance with timelines specified by EOHHS. The workplan shall:

2.2.2.1.1. Address all of the items listed in **Section 2.2.3**, at a minimum, for each County in which the Contractor has contracted with EOHHS to serve Enrollees.

2.2.2.1.2. List each task, the date by which it will be completed, how it will be completed, the person(s) or team(s) accountable for the task, and the documentation that will be provided to EOHHS as evidence that the task has been completed.

2.2.2.2. EOHHS may, in its discretion, modify or reject any such workplan, in whole or in part.

2.2.2.3. The Contractor shall modify its workplan as specified by EOHHS and resubmit for approval.

2.2.3. Scope of Readiness Review

2.2.3.1. The scope of the Readiness Review shall include, but is not limited to, a review of the following elements:

2.2.3.1.1. Operational and Administration:

2.2.3.1.1.1. Staffing and resources, including Key Personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Sections 2.3.1** and **5.3**;

2.2.3.1.1.2. Delegation and oversight of Contractor responsibilities, including but not limited to capabilities of Material Subcontractors in accordance with **Sections 2.3.2.1.1.3** and **2.3.5**, and the Material Subcontractor Checklist (i.e., **Appendix K**);

2.2.3.1.1.3. Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.13**;

2.2.3.1.1.4. Program integrity and compliance, including Fraud and Abuse and other program integrity requirements in accordance with **Section 2.3.6**; and

2.2.3.1.1.5. Compliance with all Frail Elder Waiver requirements as specified herein and in accordance with **Appendix S**.

2.2.3.1.2. Service Delivery:

2.2.3.1.2.1. Assessments and Care Planning, in accordance with **Section 2.5**;

2.2.3.1.2.2. Care Coordination, care management, and care model, in accordance with **Section 2.6**;

2.2.3.1.2.3. Reasonable accommodation capabilities, policies, and protocols;

2.2.3.1.2.4. Service Request intake, Prior Authorization, and Utilization Review, including to reflect the broader scope of Medical Necessity and the integration of Medicare and Medicaid Covered Services, in accordance with **Section 2.10**;

2.2.3.1.2.5. Quality improvement, including comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.14**;

2.2.3.1.2.6. Content of Provider Contracts, including any Provider performance incentives, in accordance with **Section 2.8.2**; and

2.2.3.1.2.7. Network Management, including Provider communications and Provider composition and access, in accordance with **Section 2.9.1**.

2.2.3.1.3. Enrollment, Enrollee Services, and Marketing:

2.2.3.1.3.1. Enrollment and Disenrollment functionality and systems in accordance with **Section 2.4**;

2.2.3.1.3.2. Enrollee Services and outreach, including capabilities (materials, processes, and infrastructure, e.g., call center capabilities), in accordance with **Section 2.11**;

2.2.3.1.3.3. Enrollee communications, including Marketing and educational materials, in accordance with **Section 2.12**; and

2.2.3.1.3.4. Provider directory (or directories), in accordance with **Section 2.8.7**.

2.2.3.1.4. Financial Management:

2.2.3.1.4.1. Financial reporting and monitoring; and

2.2.3.1.4.2. Financial solvency, in accordance with **Section 2.16**.

2.2.3.1.5. Systems Management:

2.2.3.1.5.1. Claims management; and

2.2.3.1.5.2. Encounter Data and enrollment information, as applicable, including but not limited to, at the request of EOHHS, a walk-through of any information systems, including but not limited to enrollment, claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with **Section 2.15.2**, including IT testing and security assurances.

2.2.3.1.6. A review of other items specified in the Contract, including:

2.2.3.1.6.1. Capabilities of Material Subcontractors;

2.2.3.1.6.2. Compliance with EOHHS requirements for FIDE SNPs; and

2.2.3.1.6.3. Data collection and reporting capabilities; and

2.2.3.1.6.4. Additional elements identified by EOHHS for resolution prior to Contract Execution.

2.2.4. Completing Readiness Review

2.2.4.1. The Contractor shall demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet Readiness Review requirements and all Contract requirements in sufficient time prior to the Contractor engaging in marketing of its SCO Plan and enrolling members; both of which shall be prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness.

2.2.4.2. If EOHHS identifies any deficiency in the Contractor satisfying readiness review requirements, the Contractor shall provide EOHHS, in a form and format specified by EOHHS, a remedy plan within five (5) business days of being informed of such deficiency. EOHHS, may, in its discretion, modify or reject any such remedy plan, in whole or in part.

2.2.4.3. No individual shall be enrolled into the Contractor's SCO Plan unless and until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review, except as provided below.

2.2.4.3.1. EOHHS may, in its discretion, postpone the Contract Operational Start Date for any Contractor that does not satisfy all readiness review requirements.

2.2.4.3.2. Alternatively, EOHHS may, in its discretion, permit the Contractor to enroll MassHealth Members into the Contractor's Plan effective as of the Contract Operational Start Date provided the Contractor and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

2.2.4.4. At the time of this Contract's execution, if the Contractor has not completed its Readiness Review, the Contractor shall not enroll any new individuals identified in **Sections 1.57** and **2.4.1** until the following conditions are met:

2.2.4.4.1. The Contractor obtains FIDE SNP designation for its SCO Plan for the H number and Plan Benefit Package(s) specified in **Appendix F, Exhibit 2** from CMS; and

2.2.4.4.2. EOHHS provides express written approval to the Contractor to enroll new individuals in its SCO Plan for the H number and Plan Benefit Package(s) specified in **Appendix F, Exhibit 2**.

2.2.4.5. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and EOHHS does not agree to postpone the Contract Operational Start Date or extend the date for full compliance with the applicable Contract requirement subject to a corrective action plan, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

2.3. Administration and Contract Management

2.3.1. Organization, Staffing, and Key Personnel

2.3.1.1. Structure and Governance

2.3.1.1.1. The Contractor shall:

2.3.1.1.1.1. Be located within the United States;

2.3.1.1.1.2. Not be an excluded individual or entity as described in 42 CFR 438.808(b);

2.3.1.1.1.3. Meet the definition of an MCO, as defined in 42 CFR 438.2;

2.3.1.1.1.4. Meet the federal and EOHHS criteria to qualify as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP);

2.3.1.1.1.5. Meet all application and contracting requirements established by CMS to be eligible to participate with Medicare as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP); and

2.3.1.1.1.6. Hold a D-SNP contract with CMS to operate in the Service Area approved by EOHHS for SCO and described in **Appendix F, Exhibit 1**.

2.3.1.1.2. Governing Board

2.3.1.1.2.1. The Contractor's Governing Board shall include at least one MassHealth consumer or MassHealth consumer advocate as a voting Member.

2.3.1.1.2.2. The Contractor shall submit to EOHHS a list of the Members of its Governing Board as of the Contract Effective Date and an updated list whenever any changes are made.

2.3.1.1.3. Consumer Advisory Board

2.3.1.1.3.1. The Contractor shall operate a Consumer Advisory Board for its SCO plan, with a scope and purview specific to the SCO plan, and inclusive of both the Medicaid managed care entity and this Contract, and of the Medicare contracted D-SNP organization and Medicare D-SNP Contract.

2.3.1.1.3.2. Such Consumer Advisory Board shall meet both:

2.3.1.1.3.2.1. Medicaid managed care requirements for a Member Advisory Committee as described at 42 CFR 438.110;

2.3.1.1.3.2.2. Medicare D-SNP requirements for an Enrollee Advisory Committee as described at CFR 422.107(f);

2.3.1.1.3.3. The Consumer Advisory Board for the Contractor's SCO plan shall operate independently from any other Consumer Advisory Board. The Consumer Advisory Board shall be convened to solely focus on the Contractor's SCO plan;

2.3.1.1.3.4. Duties of the Consumer Advisory Board include, but are not limited to:

2.3.1.1.3.4.1. Providing regular feedback to the Contractor's Governing Board on issues of the Contractor's SCO Plan management, Enrollee care and services, and on other solicited input;

2.3.1.1.3.4.2. Identifying and advocating for preventive care practices to be utilized by the Contractor;

2.3.1.1.3.4.3. Being involved with the development and updating of cultural and linguistic policies and procedures, including those related to Quality Improvement, education, Contractor marketing materials and campaigns, and operational and cultural competency issues affecting groups who speak a primary language other than English; and

2.3.1.1.3.4.4. Providing input and advice on Member experience survey results, ways to improve access to covered services, coordination and integration of services, and health equity for Enrolled and specific underserved sub-populations and other appropriate data and assessments, among other topics.

2.3.1.1.3.5. The Consumer Advisory Board shall be comprised of Enrollees, family members and other Enrollee caregivers.

2.3.1.1.3.6. The composition of the Consumer Advisory Board shall reflect the diversity of the SCO eligible population, including individuals with various disabilities, with a Membership that:

2.3.1.1.3.6.1. Considers cultural, linguistic, racial, disability, sexual orientation, and gender identities, among others.

2.3.1.1.3.7. EOHHS reserves the right to review and approve Consumer Membership.

2.3.1.1.3.8. The Contractor shall proactively ensure:

2.3.1.1.3.8.1. Reasonable accommodations and interpreter services, as well as other resources, are provided as may be needed to support full participation by Enrollees, their family Members, and caregivers in the Consumer Advisory Board; and

2.3.1.1.3.8.2. That the process and opportunity for joining the Consumer Advisory Board is publicized. Contractor shall conduct marketing and outreach to SCO Enrollees (or their family members or caregivers as applicable) to ensure Enrollees are aware of the opportunity to apply to join or otherwise participate.

2.3.1.1.3.9. The Contractor shall designate staff to actively engage with the Consumer Advisory Board activities and convenings, and to consider and reflect Board concerns and recommendations in the Contractor's SCO Plan policies and procedures, including the Contractor's accountable designee for Utilization Management as described in **Section 2.10.12** and the Contractor's Accessibility and Accommodations Officer described in **Section 2.10.8.**

2.3.1.1.3.10. The Contractor shall ensure that:

2.3.1.1.3.10.1. The Consumer Advisory Board meets at least quarterly throughout the Contract term.

2.3.1.1.3.10.2. The Consumer Advisory Board reports annually to the Contractor regarding the following:

2.3.1.1.3.10.2.1. The dates for all meetings held within the reporting year;

2.3.1.1.3.10.2.2. Names of Consumer Advisory Board Members invited, including identifying which invitees are actual Enrollees, family Members, or caregivers;

2.3.1.1.3.10.2.3. Names of Consumer Advisory Board Members in attendance, including identifying which attendees are actual Enrollees, family members, or caregivers,

2.3.1.1.3.10.2.4. Meeting agenda; and

2.3.1.1.3.10.2.5. Meeting minutes.

2.3.1.1.3.10.2.6. The Consumer Advisory Board's reports are provided to EOHHS as requested.

2.3.1.1.3.11. The Contractor shall also include Ombudsman reports, as available, in quarterly updates to the Consumer Advisory Board.

2.3.1.2. Key Personnel and Other Staff

2.3.1.2.1. The Contractor shall have and identify to EOHHS Key Personnel and other staff as set forth in this **Section 2.3.1.2**.

2.3.1.2.2. Key Personnel Roles

2.3.1.2.2.1. The Contractor's SCO Executive Director, or similar title, who shall have primary responsibility for the management of this Contract and shall be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract;

2.3.1.2.2.2. The Contractor's Chief Medical Officers/Medical Director, who shall be a clinician licensed to practice in Massachusetts and shall oversee Contractor's Care Delivery and Care Management activities, all clinical initiatives including quality improvement activities, including but not limited to clinical initiatives targeted to various subpopulations of Enrollees, Utilization Management programs, and the review of all appeals decisions that involve the denial of or modification of a requested Covered Service and shall attend Medical Director meetings as described in this Contract and further directed by EOHHS;

2.3.1.2.2.3. The Contractor's Pharmacy Director, or similar title, who shall be responsible for the Contractor's activities related to pharmacy Covered Services and shall attend Pharmacy

Director meetings as described in this Contract and further directed by EOHHS;

2.3.1.2.2.4. The Contractor's Behavioral Health Director, or similar title, who shall be responsible for Contractor's continuum of care and activities related to mental health and substance use disorder services and related Care Delivery and Care Management activities, and for all BH-related interaction with EOHHS, and shall attend Behavioral Health Director meetings as described in this Contract and further directed by EOHHS;

2.3.1.2.2.5. The Contractor's Long-term Services and Supports (LTSS) Director, or similar title, who shall be responsible for Contractor's continuum of care and activities related to LTSS and related Care Delivery and Care Management activities, and for all LTSS-related interaction with EOHHS;

2.3.1.2.2.6. The Contractor's Chief Financial Officer, who shall be authorized to sign and certify the Contractor's financial condition, including but not limited to attesting to the accuracy of Contractor's financial documents submitted to EOHHS, as described in this Contract and further specified by EOHHS;

2.3.1.2.2.7. The Contractor's Chief Operating Officer, who shall have primary responsibility for ensuring plan administrative and operation functions comply with the terms of this contract, including but not limited to **Sections 2.2** and **2.11**.

2.3.1.2.2.8. The Contractor's Chief Data Officer, who shall have primary responsibility for ensuring management and compliance of all activities under **Section 2.15** and **Appendix H**;

2.3.1.2.2.9. The Contractor's Compliance Officer, who shall oversee Contractor's compliance activities including Contractor's Fraud and Abuse Prevention activities as described in this Contract and further specified by EOHHS, and shall attend related meetings with EOHHS regarding fraud and abuse;

2.3.1.2.2.10. The Contractor's Accessibility and Accommodations Officer and State Agency Liaison as further described in **Section 2.3.1.2.3** below;

2.3.1.2.2.11. The SCO Legal Counsel, or similar title, who shall be the individual with responsibility for legal matters related to the Contractor's SCO plan and this Contract;

2.3.1.2.2.12. The Contractor's Ombudsman Liaison, or similar title, who shall liaise with the EOHHS's health plan Ombudsman, its contractors or its designees, to resolve issues raised by Enrollees or individuals authorized to advocate on behalf of an Enrollee;

2.3.1.2.2.13. The Contractor's designated Key Contact, who shall liaise with EOHHS and serve as the point of contact for EOHHS for all communications and requests related to this Contract;

2.3.1.2.2.13.1. The Contractor shall designate a backup for the Key Contact in the event they are not available in an emergency due to vacation or illness;

2.3.1.2.2.14. The Contractor's designated Quality Key Contact, who shall oversee the Contractor's quality management and quality improvement activities under this Contract, including those described in **Section 2.14** and other quality activities as further specified by EOHHS;

2.3.1.2.2.15. The Contractor's designated Leadership Contact, who shall serve as the contact person for the Secretary of Health and Human Services, EOHHS's Assistant Secretary for MassHealth, and as a leadership or escalation point of contact for other MassHealth program staff;

2.3.1.2.2.16. The Contractor's Care Coordination Contact, who shall liaise with EOHHS on matters related to care coordination and Care Management, including through Geriatric Support Services Coordinators and any Material Subcontractors to which such functions are delegated; and

2.3.1.2.2.17. Any other positions designated by EOHHS

2.3.1.2.3. Requirements for Certain Key Personnel

2.3.1.2.3.1. Accessibility and Accommodations Officer

2.3.1.2.3.1.1. Responsibilities of the Accessibility and Accommodations Officer shall include, but may not be limited to:

2.3.1.2.3.1.1.1. Ensuring that the Contractor and its Providers comply with federal and state laws and regulations pertaining to persons with disabilities. Such requirement shall include monitoring, evaluating, and ensuring adequate access to Covered Services and Network Providers as

described in **Section 2.7 and Section 2.9**, and that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Enrollees;

2.3.1.2.3.1.1.2. Developing and maintaining written policies and procedures describing clear and simple processes for Enrollees to make, and for the Contractor to respond to, accessibility and accommodation requests as described in **Section 2.10.8**, including standing requests for all future notifications and communication, and using data resulting from these processes to evaluate and improve such policies and procedures as needed;

2.3.1.2.3.1.1.3. Monitoring and advising on the development of, updating and maintenance of, and compliance with disability-related policies, procedures, operations, and activities, including program accessibility and accommodations in such areas as health care services, facilities, transportation, and communications;

2.3.1.2.3.1.1.4. Working with other Contractor staff on receiving, investigating, and resolving inquiries and Grievances related to issues of disability from Enrollees. Such individual shall be the point person for escalations of all inquiries and Grievances related to issues of disabilities from Enrollees;

2.3.1.2.3.1.1.5. Working with designated EOHHS, Massachusetts Office of Disability staff, and Ombudsman staff as directed by EOHHS, including being available to assist in the resolution of any problems or issues related to Enrollees; and

2.3.1.2.3.1.1.6. Upon request of EOHHS, participating in meetings or workgroups related to the needs and care of Enrollees with disabilities.

2.3.1.2.3.2. State Agency Liaison

2.3.1.2.3.2.1. The State Agency Liaison shall have the following responsibilities:

2.3.1.2.3.2.1.1. Work with designated EOHHS staff and the state agency leadership, including but not limited to for

the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Public Health (DPH) and the DPH Bureau of Substance Addiction Services (BSAS), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), MassAbility, and the Executive Office of Aging & Independence (AGE);

2.3.1.2.3.2.1.2. Be responsible for collaboration, communication, and coordination with state agencies as needed based on Enrollee affiliations, services, and other needs;

2.3.1.2.3.2.1.3. Establish and maintain contact with designated state agency staff and assist in the resolution of any problems or issues that may arise with an Enrollee affiliated with each such agency;

2.3.1.2.3.2.1.4. As requested by EOHHS, participate in regional informational and educational meetings with state agency staff and as directed by EOHHS, individuals, caregivers, or other family member(s);

2.3.1.2.3.2.1.5. As requested by EOHHS, provide advice and assistance to DDS, DMH, DPH, MassAbility, MCB, MCDHH, and other State agencies as may be needed, on individual cases regarding Covered Services and coordinating non-covered Services provided by State agencies other than MassHealth;

2.3.1.2.3.2.1.6. As requested by EOHHS, actively participate in any joint meetings or workgroups with State agencies; and

2.3.1.2.3.2.1.7. Coordinate the Contractor's interaction with state agencies with which Enrollees may have an affiliation.

2.3.1.2.4. Appointing Key Personnel

2.3.1.2.4.1. The Contractor shall appoint an individual to each of the roles listed in **Section 2.3.1.2**. The Contractor may appoint a single individual to more than one such role;

2.3.1.2.4.2. Key personnel, except the Chief Financial Officer, Chief Operations Officer, and Chief Data Officer, shall be based in Massachusetts (i.e., physically present within the Commonwealth on a regular basis) to ensure local control;

2.3.1.2.4.3. The Contractor shall have appointments to all Key Personnel roles no later than ninety (90) days prior to the Contract Operational Start Date, and shall notify EOHHS of such initial appointments;

2.3.1.2.4.4. Key Personnel shall, for the duration of the Contract, be employees of the Contractor, shall not be Material Subcontractors, and shall be assigned primarily to perform their job functions related to this Contract;

2.3.1.2.4.5. Contractor shall supply EOHHS with a Key Personnel and Contact list that contains the name, email address, and phone number for all Key Personnel and for any additional key contacts. Upon any changes in Key Personnel or key contacts, the Contractor shall supply EOHHS with an updated Key Personnel and Contact list no less than five (5) business days after such a change is made;

2.3.1.2.4.6. Contractor shall supply EOHHS with an organizational chart indicating where Key Personnel reside within the Contractor's corporate structure, their supervisors, and direct reports. The Contractor shall supply EOHHS with updates as changes in the corporate structure are made (**See Appendix A**);

2.3.1.2.4.7. The Contractor shall, when subsequently hiring, replacing, or appointing individuals to Key Personnel roles, notify EOHHS of such a change and provide the name(s) and resumes of such qualified individuals to EOHHS no less than five (5) business days after such a change is made;

2.3.1.2.4.8. If EOHHS informs the Contractor that EOHHS is concerned that any Key Personnel are not performing the responsibilities described in this Contract or are otherwise hindering Contractor's successful performance of the responsibilities of this Contract, the Contractor shall investigate such concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS of such actions. Failure to resolve the matter to EOHHS's satisfaction may result in an intermediate sanction and corrective action under **Section 5.4**;

2.3.1.2.5. Local Control

2.3.1.2.5.1. The Contractor's local management team for Massachusetts, including Key Personnel described above shall have the necessary authority and accountability to carry out contractually necessary functions and responsibilities defined in this Contract. Any centralized functions shall have accountability to the Contractor's local management team for Massachusetts. Key Personnel and their staff working on the Massachusetts SCO Plan shall be familiar with MassHealth, applicable state and federal regulations and requirements, the Massachusetts healthcare delivery system, the standards and practices of care in Massachusetts, and best practices in their area of responsibility.

2.3.1.2.5.2. The Contractor, and its Material Subcontractors as applicable, shall employ sufficient Massachusetts-based staffing and resources to carry out all functions and activities necessary to operate the SCO Plan, and as otherwise required under this Contract. Such staff shall be familiar with MassHealth and with applicable State and federal regulations and requirements.

2.3.1.2.5.3. The Contractor shall ensure that its organizational structure, policies, and processes enable its local management team for Massachusetts to rapidly respond to local issues and needs.

2.3.1.2.5.4. The Contractor shall disclose the percentage of the Contractor's care coordination employees and contracted staff that will be located within or close enough to Massachusetts to regularly engage in-person with Enrollees, (see also **Appendix A**).

2.3.1.2.6. Organizational Structure

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

2.3.1.2.6.2. The Contractor shall establish, maintain, and describe the interdepartmental structures and processes to support the operation and management of its SCO Plan line of business in a manner that fosters integration of physical and

behavioral health service provision. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The Contractor's Behavioral Health Services and activities should be person centered, and oriented to recovery and rehabilitation from behavioral health conditions.

2.3.1.2.6.3. On an annual basis, upon request, and on an ad hoc basis when changes occur or as directed by EOHHS, the Contractor shall submit to EOHHS an overall organizational chart that includes senior and mid-level managers for the organization, as well as any additional staff who engage with EOHHS or CMS.

2.3.1.2.6.4. The organizational chart shall include the organizational staffing for Behavioral Health Services and activities. If such Behavioral Health Services and activities are provided by a Material Subcontractor, the Contractor shall submit the organizational chart of the behavioral health Material Subcontractor which clearly demonstrates the relationship with the Material Subcontractor and the Contractor's oversight of the Material Subcontractor.

2.3.1.2.6.5. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies are anticipated to be filled.

2.3.1.2.6.6. For all employees, by functional area, the Contractor shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to EOHHS upon request.

2.3.1.2.6.7. For Personnel described in **Section 2.3.1.2**. and any other key management positions, including the designated "key contact," the Contractor shall immediately notify EOHHS whenever the position becomes vacant and notify EOHHS when the position is filled and by whom.

2.3.2. Contract Management and Responsiveness to EOHHS

2.3.2.1. General

2.3.2.1.1. The Contractor shall:

2.3.2.1.1.1. Ensure its compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.3.2.1.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the Request for Responses (RFR) and approved by EOHHS;

2.3.2.1.1.3. Oversee all activities by the Contractor's Material Subcontractors and Providers; and

2.3.2.1.1.4. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network.

2.3.2.1.2. The Contractor shall ensure and demonstrate appropriate responsiveness to EOHHS requests related to this Contract, including ensuring availability of Contractor's staff with appropriate expertise to EOHHS upon request.

2.3.2.2. Contract Management and Performance Review Meetings

2.3.2.2.1. The Contractor shall attend regular Contract management and performance review meetings as directed by EOHHS.

2.3.2.2.2. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise, as requested by EOHHS, attend such meetings.

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

2.3.2.2.3.1. Reports, in a form and format approved by EOHHS and as specified in **Appendix A**, related to the Contractor's performance under this Contract. Unless otherwise specified, such information shall be reported for Medicaid, for Medicare, and in aggregate. Information requested may include, but shall not be limited to measures such as:

2.3.2.2.3.1.1. Revenue, cost, and utilization data for Enrollees by Rating Category and category of service;

2.3.2.2.3.1.2. Performance reporting information;

2.3.2.2.3.1.3. Quality Measure performance;

2.3.2.2.3.1.4. Measures of Enrollee utilization across categories of service and other indicators of changes in patterns of care;

2.3.2.2.3.1.5. Denials and/or approvals of Service Requests and Prior Authorizations by service category and type, including supporting information;

2.3.2.2.3.1.6. Internal Appeals and External Appeals for both Medicare and MassHealth, by service category and type, and disposition, timeliness, continuing services requests and actions, and implementation of appeals actions favorable to the Enrollee;

2.3.2.2.3.1.7. Drivers of financial, quality, or utilization performance, including but not limited to stratified utilization data by service categories, drug and procedure types, provider type;

2.3.2.2.3.1.8. Measures showing impact of Network Provider payments varying from MassHealth fee schedule payments and Original Medicare fee schedule payments;

2.3.2.2.3.1.9. Financial projections and models showing impact of certain actions specified by EOHHS;

2.3.2.2.3.1.10. Analysis related to completeness and validity of any data submissions made to EOHHS;

2.3.2.2.3.1.11. Opportunities the Contractor identifies to improve performance, and plans to improve such performance, including plans proposed to be implemented by the Contractor for Network Providers, and Material Subcontractors;

2.3.2.2.3.1.12. Changes in Contractor's staffing and organizational development;

2.3.2.2.3.1.13. Performance of Material Subcontractors including but not limited to any changes in or additions to Material Subcontractor relationships;

2.3.2.2.3.1.14. Health Equity data completion and disparities reduction metrics as further specified by EOHHS;

2.3.2.2.3.1.15. Marketing, education, and enrollment activities; and

2.3.2.2.3.1.16. Any other measures deemed relevant by the Contractor or requested by EOHHS.

2.3.2.2.3.2. Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities; and

2.3.2.2.3.3. Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS.

2.3.2.2.4. The Contractor shall, within two (2) business days following each contract management or performance review meeting, prepare and submit to EOHHS for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by EOHHS.

2.3.2.3. Timely Response to EOHHS Requests

2.3.2.3.1. The Contractor shall respond to all inquiries and requests made by EOHHS in time frames and formats specified by EOHHS, including requests for review, analysis, information, or other materials related to the Contractor's performance of this Contract. Such requests may include but are not limited to requests for:

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

2.3.2.3.1.2. Analysis of utilization, timeliness of access to care, patterns of care, cost, and other characteristics to identify opportunities to improve the Contractor's performance on any cost, quality, Member experience, or outcome measures related to this Contract;

2.3.2.3.1.3. Financial and data analytics, such as the Contractor's payment rates to Network Providers as a percent of MassHealth's fee schedules, Original Medicare fee schedules, or other benchmarks as requested by EOHHS;

2.3.2.3.1.4. Documentation and supporting information in a form and format specified by EOHHS related to Enrollee case escalations, critical incidents, and service denials, including partial denials;

2.3.2.3.1.5. Information regarding the Contractor's contracts and agreements with Medicare ACO Providers, MassHealth ACO

Providers, and other Network Providers, including on payment, risk sharing, performance, and incentive arrangements;

2.3.2.3.1.6. Information regarding the payer revenue mix of the Contractor's Network Providers;

2.3.2.3.1.7. Documentation and information related to the Contractor's care delivery, Care Management, or Material Subcontractor responsibilities, to assist EOHHS with understanding the Contractor's activities pursuant to these requirements;

2.3.2.3.1.8. Information about the Contractor's Member protections activities, such as Grievances and Appeals;

2.3.2.3.1.9. Documentation and information related to the Contractor's program integrity activities as described in this Contract;

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

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

2.3.2.3.1.12. Information about the Contractor's D-SNP, including but not limited to, the D-SNP's administration, operations, performance, quality, claims processing, and service authorization criteria.

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

2.3.2.4. Performance Reporting

2.3.2.4.1. EOHHS may, at its discretion and at any time, identify certain Contract requirements and other performance and quality measures about which the Contractor shall report to EOHHS. If EOHHS is concerned with the Contractor's performance on such measures, the Contractor shall discuss such performance with EOHHS and as further specified by EOHHS:

2.3.2.4.1.1. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports; and

2.3.2.4.1.2. Provide EOHHS with, and implement as approved by EOHHS, a concrete plan for improving its performance.

2.3.2.5. Public Reporting

2.3.2.5.1. The Contractor shall, in a form and format specified by EOHHS, post on its website, Service Authorization metrics and other information as required by the CMS Interoperability and Prior Authorization Final Rule. Such data may include information collected through contract management and performance reporting described in this **Section 2.3.2**.

2.3.2.6. Ad Hoc Meetings

2.3.2.6.1. The Contractor shall attend ad hoc meetings for the purposes of discussing this Contract via videoconference, at EOHHS's offices, or at another location determined by EOHHS, as requested by EOHHS.

2.3.2.6.2. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present, including in person as specified, at such meetings, as requested by EOHHS, including but not limited to the Contractor's SCO Executive Director.

2.3.2.6.3. The Contractor shall prepare materials and information for such meetings as further directed by EOHHS.

2.3.2.7. Participation in EOHHS Efforts

2.3.2.7.1. As directed by EOHHS, the Contractor shall participate in any:

2.3.2.7.1.1. Efforts to promote the delivery of services in a Culturally and Linguistically Appropriate manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity;

2.3.2.7.1.2. EOHHS activities related to Health Equity;

2.3.2.7.1.3. EOHHS activities related to Program Integrity;

2.3.2.7.1.4. Activities to verify or improve the accuracy, completeness, or usefulness of Contractor's data submissions to EOHHS, including but not limited to validation studies of such data;

2.3.2.7.1.5. Activities related to EOHHS's implementation and administration of its integrated care program efforts, including improving Medicare-Medicaid integration and the integration of physical health services, behavioral health services, and Long-term Services and Supports;

2.3.2.7.1.6. SCO shared learning opportunities, joint performance management activities, and other meetings or initiatives by EOHHS to facilitate information sharing and identify best practices among integrated care plans. The Contractor shall share information with EOHHS, and others as directed by EOHHS regarding the Contractor's performance under this Contract, including but not limited to information on the Contractor's business practices, procedures, infrastructure, and information technology;

2.3.2.7.1.7. EOHHS efforts related to the development of EOHHS policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, including but not limited to The Roadmap to Behavioral Health Reform (or the BH Roadmap);

2.3.2.7.1.8. Enrollment, disenrollment, or attribution activities related to this Contract;

2.3.2.7.1.9. Training programs, including training curricula and outcomes;

2.3.2.7.1.10. Coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor;

2.3.2.7.1.11. Workgroups and councils, including but not limited to workgroups related to reporting or data submission specifications;

2.3.2.7.1.12. Educational sessions for EOHHS staff, such as but not limited to trainings for EOHHS's Customer Service Team;

2.3.2.7.1.13. Site visits and other reviews and assessments by EOHHS; and

2.3.2.7.1.14. Any other activities related to this Contract.

2.3.2.7.2. As directed by EOHHS, the Contractor shall comply with all applicable requirements resulting from EOHHS initiatives.

2.3.2.7.3. The Contractor shall participate in all statewide stakeholder and oversight meetings as requested by EOHHS.

2.3.2.7.4. The Contractor shall comply with all applicable administrative bulletins, technical instructions, specification documents, and other applicable guidance issued by EOHHS.

2.3.2.8. Policies and Procedures for Core Functions

2.3.2.8.1. The Contractor shall develop, maintain, and provide to EOHHS upon request, policies and procedures for all core functions necessary to manage the SCO eligible and enrolled population effectively and efficiently and meet the requirements outlined in this Contract. All policies and procedures requiring EOHHS approval shall be documented and shall include the dates of approval by EOHHS.

2.3.2.8.2. These policies and procedures shall include, but are not limited to, the following topics:

2.3.2.8.2.1. Response to violations of Enrollees' privacy rights by staff, Providers or Material Subcontractors;

2.3.2.8.2.2. Non-discrimination of Enrollees;

2.3.2.8.2.3. Non-restriction of Providers advising or advocating on an Enrollee's behalf;

2.3.2.8.2.4. Enrollee cooperation with those providing health care services;

2.3.2.8.2.5. Marketing activities that apply to the Contractor, Providers, and Material Subcontractors, including both Medicare and Medicaid activities, as well as the Contractor's procedures for monitoring these activities;

2.3.2.8.2.6. Cost-sharing by Enrollees;

2.3.2.8.2.7. Advance directives;

2.3.2.8.2.8. Assisting Enrollees in understanding their benefits and how to access them;

2.3.2.8.2.9. Access and availability standards;

2.3.2.8.2.10. Enrollee rights in accordance with **Appendix N** and in accordance with 42 CFR 438.100;

2.3.2.8.2.11. Enrollees' right to be free from restraint or seclusion used as a means of coercion or retaliation;

2.3.2.8.2.12. The provision of Culturally and Linguistically Appropriate Services;

2.3.2.8.2.13. Practice guidelines in quality measurement and improvement activities;

2.3.2.8.2.14. Compliance with Emergency Services and Post-stabilization Care Services requirements as identified in 42 CFR 438.114;

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

2.3.2.8.2.16. Handling of inquiries and Grievances sent directly to EOHHS;

2.3.2.8.2.17. Process used to monitor Provider and Material Subcontractor implementation of amendments and improvements;

2.3.2.8.2.18. Retention of medical records;

2.3.2.8.2.19. Engagement and coordination with Geriatric Support Services Coordinators contracted from ASAPs;

2.3.2.8.2.20. Care Management and Care Coordination;

2.3.2.8.2.21. In-person engagement for various assessment, care coordination and care planning activities;

2.3.2.8.2.22. Provision of services in an Enrollee’s home;

2.3.2.8.2.23. Public health emergencies;

2.3.2.8.2.24. Risk stratification; and

2.3.2.8.2.25. Claims processing.

2.3.2.9. The Contractor shall within three (3) business days disclose to EOHHS its application for, or participation in, any federal or state alternative payment methodologies, delivery system innovations, health equity, or care model improvement initiatives, including through the Center for Medicare and Medicaid Innovation (CMMI).

2.3.3. FIDE SNP Medicare Contract Requirements

2.3.3.1. The Contractor shall operate a Medicare Advantage Dual Eligible Special Needs Plan for its SCO plan in Massachusetts under a unique CMS Medicare contract number ("H number"), subject to CMS approval, separate from all other Medicare Advantage contracts offered by the Contractor, as indicated in 42 CFR 422.107(e)(1)(i).

2.3.3.2. If the Contractor operates both a One Care plan and a SCO plan in Massachusetts, the Contractor shall operate the One Care plan and the SCO plan under separate unique CMS Medicare contract numbers ("H numbers"), subject to CMS approval, and as indicated in 42 CFR 422.107(e)(1)(i).

2.3.3.3. The Contractor shall submit Plan Benefit Packages (PBPs) to CMS for its SCO plan according to the eligibility criteria in **Appendix F, Exhibit 2**.

2.3.3.3.1. The Contractor shall annually submit to EOHHS for approval proposed PBP eligibility criteria for its SCO Plan no later than May 20th of the calendar year immediately prior to the applicable Contract Year for the PBP(s) (i.e., submit CY 2026 PBPs by May 20, 2025).

2.3.3.3.2. EOHHS shall review the Contractor's proposed PBP eligibility criteria and, if EOHHS identifies any deficiencies, EOHHS shall collaborate with the Contractor to remediate and resolve those deficiencies to EOHHS's satisfaction prior to the Contractor's PBP submission to CMS.

2.3.3.3.3. Annually, upon EOHHS approval of the Contractor's PBP eligibility criteria, the Contractor and EOHHS shall amend **Appendix F, Exhibit 2**, as applicable, with the EOHHS-approved PBP eligibility criteria for the applicable Contract Year. The Contractor shall submit its SCO PBP(s) to CMS in accordance with the approved criteria specified in **Appendix F, Exhibit 2**.

2.3.3.3.4. The Contractor shall submit crosswalk exception requests to CMS annually as described in 42 CFR 422.530(c)(4)(i), to align current D-SNP Enrollees to the PBP for which they are eligible for the following benefit year, as described in **Appendix F, Exhibit 2**. Such Enrollees may remain enrolled in their current PBP until the end of the current Contract Year.

2.3.3.4. The Contractor shall submit to EOHHS Marketing, Outreach, and Enrollee Communication materials as described in **Section 2.12**, as well as information about its performance, model, benefits, risk scores, and other elements pertaining to the operation of its SCO Plan under a FIDE SNP model, as further described in this Contract. EOHHS may waive this requirement for any information sufficiently available to EOHHS

through CMS' Health Plan Management System (HPMS), including in an acceptable form and format.

2.3.3.5. The Contractor shall submit to EOHHS reports and materials related to its operation as a FIDE SNP for the Medicare Advantage contract and PBPs covered by this Contract, as described in **Appendix A**. Certain financial information, including the Contractor's bid to CMS, risk score information, and Medicare Supplemental Benefit information shall also be submitted to EOHHS, as directed by EOHHS.

2.3.4. Service Area Expansion

2.3.4.1. The Contractor may request to expand its Service Area as follows:

2.3.4.1.1. In the event the Contractor intends to pursue a Service Area Expansion (SAE), the Contractor shall submit a request in writing to EOHHS for approval of its SAE request no later than 13 months (December 1 of the prior calendar year) prior to the Contract Year the SAE would take effect. Such notification shall minimally include a list of any Counties for which the Contractor is proposing to expand its Service Area, as well as its projected enrollment in each proposed new County for the Contract Year in which it first covers each such County. EOHHS may establish additional criteria for SAE proposals.

2.3.4.1.2. The Contractor may propose SAEs only for full county coverage.

2.3.4.2. EOHHS shall review the Contractor's request for SAE and provide the Contractor with a response (as described in **Section 2.3.4.3**) prior to the annual CMS deadline for submission of Medicare applications for SAEs.

2.3.4.3. EOHHS may, in its sole discretion, grant in full, grant in part, or deny the Contractor's requested SAE, including for the purpose of limiting the total number of Plans operating in each County.

2.3.4.4. The Contractor may submit a SAE request to CMS for its Medicare D-SNP only with EOHHS's prior approval, as described in **Section 2.3.4.1.1**.

2.3.4.5. Upon request, the Contractor shall provide to EOHHS all documentation submitted to CMS regarding such SAE requests;

2.3.4.6. In the event that EOHHS and CMS approve the Contractor's requested Service Area expansion, whether in full or in part, the Contractor and EOHHS shall amend **Appendix F, Exhibit 1** accordingly; and

2.3.4.7. Prior to the Contractor accepting Enrollments in an expanded Service Area, the Contractor shall provide to EOHHS all information EOHHS

deems necessary to complete a readiness review of network adequacy, staffing requirements, and related implementation requirements.

2.3.5. Material Subcontractors

2.3.5.1. All Contractor requirements set forth in this Contract that are relevant to the arrangement between the Contractor and Material Subcontractor shall apply to Material Subcontractors as further specified by EOHHS.

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

2.3.5.3. All Material Subcontracts shall be prior approved by EOHHS, except for those with External Brokers as described in **Section 2.12.2**. To obtain such approval, the Contractor shall make a request in writing and submit with that request a completed Material Subcontractor checklist report as set forth in **Appendix A** using the template (**Appendix K**) provided by EOHHS as it may be modified by EOHHS from time-to-time. The Contractor shall submit the completed **Appendix K** as part of the Readiness Review (see **Section 2.2.3.1.1.2**), and during the Contract Term for any changes in Material Subcontractors, as required in **Appendix A**.

2.3.5.3.1. For Material Subcontractors who are not pharmacy benefit managers or Behavioral Health Subcontractors, the Contractor shall submit such report to EOHHS at least sixty (60) calendar days prior to the date the Contractor expects to execute the Material Subcontract.

2.3.5.3.2. The Contractor shall submit such report for pharmacy benefit managers and Behavioral Health Subcontractors ninety (90) calendar days prior to the date the Contractor expects to execute the Material Subcontract.

2.3.5.3.3. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the Material Subcontractor checklist report. For Material Subcontractors who are pharmacy benefit managers, the Contractor shall provide a network adequacy report at EOHHS’s request.

2.3.5.4. The Contractor's contract, agreement, or other arrangement with a Material Subcontractor shall:

2.3.5.4.1. Be a written agreement;

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

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

2.3.5.4.4. Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable sub-regulatory guidance, including but not limited to federally required disclosure requirements set forth in this Contract; and

2.3.5.4.5. Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the written agreement with the Material Subcontractor requires the Material Subcontractor to agree as follows. See also **Section 5.5**.

2.3.5.4.5.1. The State, CMS, HHS Inspector General, the Comptroller General, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract. This right exists through ten (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

2.3.5.4.5.2. The Material Subcontractor shall make its premises, facilities, staff, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above.

2.3.5.4.6. Stipulate, or the Contractor shall make best efforts to stipulate, that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Material Subcontractor is based.

2.3.5.5. The Contractor shall monitor any Material Subcontractor's performance on an ongoing basis and perform a formal review annually. If any deficiencies or areas for improvement are identified, the Contractor shall require the Material Subcontractor to take corrective action. The Contractor shall notify EOHHS of any corrective action within two (2) business days of issuing such action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result.

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

transition or related activities as described in **Section 2.6, 2.8.1, 2.10.7,** and elsewhere in this Contract.

2.3.5.7. In accordance with **Appendix A**, the Contractor shall regularly submit to EOHHS a report containing a list of all Material Subcontractors. Such report shall also indicate whether any of its Material Subcontractors are a business enterprise (for-profit) or non-profit organization certified by the Commonwealth's Supplier Diversity Office. The Contractor shall submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the report.

2.3.5.8. The Contractor shall remain fully responsible for complying with and meeting all of the terms and requirements of the Contract as well as complying with all applicable state and federal laws, regulations, and guidance, 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.

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

2.3.6. Program Integrity

2.3.6.1. General Provisions

2.3.6.1.1. The Contractor shall:

2.3.6.1.1.1. Comply with all applicable federal and state program integrity laws and regulations regarding Fraud, Waste, and Abuse, including but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456.

2.3.6.1.1.2. Implement and maintain written internal controls, policies and procedures, and administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, correct and report known or suspected Fraud, Waste, and Abuse activities consistent with 42 CFR 438.608(a) and as further specified in this Contract.

2.3.6.1.1.3. In accordance with federal law, including but not limited to 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 such Section 6032, the Contractor’s policies, M.G.L. Ch. 12,

Section 5J, and the rights of employees to be protected as whistleblowers.

2.3.6.1.1.4. Meet with EOHHS regularly and upon request to discuss Fraud, Waste, and Abuse, audits, overpayment issues, reporting issues, and best practices for program integrity requirements.

2.3.6.1.1.5. At EOHHS's 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, and mutually agreed upon best practices for program integrity requirements.

2.3.6.2. Compliance Plan

2.3.6.2.1. The Contractor shall, in accordance with 42 CFR 438.608(a)(1), have a compliance plan designed to guard against Fraud, Waste and Abuse.

2.3.6.2.2. At a minimum, the Contractor's compliance plan shall include the following:

2.3.6.2.2.1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws regarding Fraud, Waste and Abuse;

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

2.3.6.2.2.3. 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;

2.3.6.2.2.4. Effective training and education for the Contractor's employees, including but not limited to the Contractor's compliance officer and senior management;

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

2.3.6.2.2.6. Enforcement of standards through well-publicized disciplinary guidelines;

2.3.6.2.2.7. Provision for internal monitoring and auditing as described in 42 CFR 438.608;

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

2.3.6.2.2.9. Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this **Section 2.3.6.2.**

2.3.6.2.3. The Contractor's compliance plan shall be in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with **Appendix A**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

2.3.6.3. Anti-Fraud, Waste, and Abuse Plan

2.3.6.3.1. The Contractor shall have an anti-Fraud, Waste, and Abuse plan.

2.3.6.3.2. The Contractor's anti-Fraud, Waste, and Abuse plan shall, at a minimum:

2.3.6.3.2.1. Require reporting of suspected and confirmed Fraud, Waste, and Abuse consistent with this Contract;

2.3.6.3.2.2. Include a risk assessment of the Contractor's various Fraud, Waste, and Abuse and program integrity processes, a listing of the Contractor's top three vulnerable areas, and an outline of action plans in mitigating such risks.

2.3.6.3.2.2.1. The Contractor shall submit to EOHHS this risk assessment quarterly at EOHHS's request and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines).

2.3.6.3.2.2.2. With such submission, the Contractor shall provide details of such action and outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, Waste, and Abuse to ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's compliance plan and anti-Fraud, Waste, and Abuse plan,

2.3.6.3.2.3. Outline activities for Provider education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, Waste, and Abuse, specifically related to identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments,

2.3.6.3.2.4. Contain procedures designed to prevent and detect Fraud, Waste, and Abuse in the administration and delivery of services under this Contract, and

2.3.6.3.2.5. Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, Waste, and Abuse, such as:

2.3.6.3.2.5.1. A list of automated pre-payment claims edits;

2.3.6.3.2.5.2. A list of automated post-payment claims edits;

2.3.6.3.2.5.3. A description of desk and onsite audits performed on post-processing review of claims;

2.3.6.3.2.5.4. A list of reports of Provider profiling and credentialing used to aid program and payment integrity reviews;

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

2.3.6.3.2.5.6. A list of provisions in the Material Subcontractor and Provider Contracts that ensure the integrity of provider credentials.

2.3.6.3.2.6. The Contractor shall have its anti-Fraud, Waste, and Abuse plan in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with Appendix A, annually, and when otherwise requested. The

Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

2.3.6.4. Overpayments

2.3.6.4.1. Reporting MassHealth Overpayments to EOHHS

2.3.6.4.1.1. This **Section 2.3.6.4** shall apply to overpayments for Medicaid-primary services, this **Section 2.3.6.4** shall not apply to overpayments for Medicare covered services.

2.3.6.4.1.2. The Contractor shall report MassHealth overpayments to EOHHS using the following reports as specified below and in **Appendix A**:

2.3.6.4.1.2.1. Notification of Provider Overpayments Report;

2.3.6.4.1.2.2. Fraud and Abuse Notification Report;

2.3.6.4.1.2.3. Summary of Provider Overpayments Report;

2.3.6.4.1.2.4. Self-Reported Disclosures Report; and

2.3.6.4.1.2.5. Monthly Identified and Recovered Overpayment Report

2.3.6.4.1.3. In accordance with **Appendix A**, the Contractor shall submit to EOHHS the Notification of Provider Overpayments Report and Fraud and Abuse Notification Report no later than five (5) business days after the identification of the overpayment.

2.3.6.4.1.4. In accordance with **Appendix A**, the Contractor shall submit to EOHHS the Summary of Provider Overpayments Report as follows:

2.3.6.4.1.4.1. The Contractor shall report all overpayments identified, including but not limited to those resulting from potential Fraud, as further specified by EOHHS.

2.3.6.4.1.4.2. The Contractor shall, as further specified by EOHHS, report all overpayments identified during the Contract Year, regardless of dates of service, and all investigatory and recovery activity related to those overpayments. This report shall reflect all cumulative activity for the entire contract year plus six (6) months after the end of the contract year.

2.3.6.4.1.4.3. For any overpayments that remain unrecovered for more than six (6) months after the end of the Contract Year, the Contractor shall continue to report all cumulative activity on such overpayments until all collection activity is completed.

2.3.6.4.2. Identifying and Recovering Overpayments:

2.3.6.4.2.1. If the Contractor identifies an overpayment prior to EOHHS:

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

2.3.6.4.2.1.2. In the event the Contractor does not recover an overpayment first identified by the Contractor within one hundred and eighty (180) days after such identification, the Contractor shall provide justification in the Summary of Provider Overpayments report for any initial overpayment amounts identified but not recovered. EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with this **Section 2.3.6.4.2**.

2.3.6.4.2.2. If EOHHS identifies an overpayment prior to the Contractor that the Contractor did not identify and report to EOHHS in accordance with all applicable Contract requirements:

2.3.6.4.2.2.1. Within ninety (90) days of EOHHS's notification of the overpayment, the Contractor shall investigate the associated claims and notify EOHHS as to whether the Contractor agrees with or disputes EOHHS's findings, in the Response to Overpayments Identified by EOHHS Report as specified in **Appendix A**.

2.3.6.4.2.2.2. If the Contractor disputes EOHHS's finding, the Contractor's response shall provide a detailed description of the reasons for the dispute, listing the claim(s) and amount of each overpayment in dispute.

2.3.6.4.2.2.3. If the Contractor agrees with EOHHS's finding:

2.3.6.4.2.2.3.1. The Contractor's response shall provide the amount of each overpayment agreed to.

2.3.6.4.2.2.3.2. The Contractor shall complete collections of such agreed-upon overpayments. The Contractor shall submit a report to EOHHS of such collections

within ninety (90) days of the Contractor's response to EOHHS's notification, in the Agreed Upon Overpayments Collection Report as specified **in Appendix A**.

2.3.6.4.2.2.4. In the event the Contractor recovers an agreed-upon overpayment first identified by EOHHS within ninety (90) days of the Contractor's response to EOHHS's notification, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount in accordance with this **Section 2.3.6.4.2**. The Contractor shall retain the remaining 20% of the agreed-upon overpayment amount collected. In the event EOHHS determines that there is a valid justification for any agreed-upon overpayment amounts that cannot be collected (e.g., MFD hold), this Capitation Payment deduction shall be calculated based on the amount collected instead of the initial agreed-upon overpayment amount.

2.3.6.4.2.2.5. In the event the Contractor does not recover an overpayment first identified by EOHHS within ninety (90) days of the Contractor's response to EOHHS's notification, without providing sufficient justification for any initial overpayment amounts identified but not recovered as determined by EOHHS, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with this **Section 2.3.6.4.2.**

2.3.6.4.2.2.6. No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases.

2.3.6.4.2.2.7. EOHHS shall calculate, following the end of the Contract Year, all Capitation Payment deductions for the prior Contract Year pursuant to this **Section 2.3.6.4.2.**

2.3.6.4.2.2.8. In the alternative to the above process, EOHHS may, in its discretion, recover the overpayment and may retain any overpayments collected.

2.3.6.4.3. Other Requirements Regarding Overpayments

2.3.6.4.3.1. The Contractor shall maintain and require its Providers to use a mechanism for the Provider to report when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment. The Contractor shall report any such notifications by its Providers to EOHHS in the Self-Reported Disclosures report.

2.3.6.4.3.2. The Contractor may not act to recoup improperly paid funds or withhold funds potentially due to a Provider when the issues, services or claims upon which the recoupment or withhold is based on the following:

2.3.6.4.3.2.1. The improperly paid funds were recovered from the Provider by EOHHS, the federal government or their designees, as part of a criminal prosecution where the plan had no right of participation; or

2.3.6.4.3.2.2. The improperly paid funds currently being investigated by EOHHS are the subject of pending federal or state litigation or investigation, or are being audited by EOHHS, the Office of the State Auditor, CMS, Office of the Inspector General, or any of their agents.

2.3.6.5. Suspected Fraud

2.3.6.5.1. Contractor Obligations

2.3.6.5.1.1. Report, within five (5) business days, in accordance with **Appendix A** and all other Contract requirements, any allegation of Fraud, Waste, or Abuse regarding an EOHHS client or Commonwealth contractor as defined under 42 CFR 455.2 or other applicable law to EOHHS;

2.3.6.5.1.2. Notify EOHHS and receive EOHHS's approval to make such contact, prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

2.3.6.5.1.3. Take no action on any claims which form the basis of a Fraud referral to EOHHS, including refraining from voiding or denying such claims, as well as refraining from any attempts to collect overpayments on such claims;

2.3.6.5.1.4. Provide to EOHHS an annual certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding suspected

Fraud including but not limited to the requirement to report any allegation of Fraud to EOHHS; and

2.3.6.5.1.5. Suspend payments to Providers for which EOHHS determines there is a credible allegation of Fraud pursuant to 42 CFR 455.23, or as further directed by EOHHS, unless EOHHS identifies or approves the Contractor's request for a good cause exception as set forth in **Section 2.9.8.2.10**.

2.3.6.5.1.5.1. As further directed by EOHHS, after the conclusion of a Fraud investigation that results in a verdict or settlement obtained by the Office of the Attorney General (AGO) Medicaid Fraud Division, the Contractor shall disburse to EOHHS any money the Contractor held in a payment suspension account connected to the investigation to account for the verdict or settlement.

2.3.6.5.1.5.2. As further directed by EOHHS, if the amount of money the Contractor held in the payment suspension account exceeds the Provider's liability under the verdict or settlement, the Contractor shall release to the Provider the amount of money that exceeds the Provider's liability under the verdict or settlement.

2.3.6.5.1.5.3. As further directed by EOHHS, if EOHHS determines the Contractor may receive a finders' fee performance incentive as described in **Section 4.7.3** below, the Contractor may retain any money in a payment suspension account necessary to satisfy all or part of the amount of such finders' fee performance incentive. If the Contractor is entitled to a finder's fee performance incentive in an amount greater than the amount held in a payment suspension account, EOHHS will pay the Contractor the difference between the amount of the performance incentive and the amount in the payment suspension account.

2.3.6.5.1.6. The Contractor and, where applicable, its Material Subcontractors shall cooperate, as reasonably requested in writing, with the Office of the Attorney General's Medicaid Fraud Division (MFD), the Office of the State Auditor's Bureau of Special Investigations (BSI), or other applicable enforcement agency. Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their

responsibilities regarding fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

2.3.6.5.2. Monetary Recoveries by the Office of the Attorney General's Medicaid Fraud Division

2.3.6.5.2.1. Except as otherwise provided within this **Section 2.3.6.5.2**, EOHHS shall retain all monetary recoveries made by MFD arising out of a verdict or settlement with Providers.

2.3.6.5.2.2. The Contractor shall receive a finders' fee performance incentive as follows:

2.3.6.5.2.2.1. To receive the finders' fee performance incentive, the Contractor shall satisfy, in EOHHS's determination, the following requirements as they relate to MFD's case against a Provider:

2.3.6.5.2.2.1.1. The Contractor made a fraud referral to EOHHS pursuant to **Section 2.3.6.5**;

2.3.6.5.2.2.1.2. The Contractor's fraud referral provided sufficient details regarding the Provider(s), conduct, and time period of the allegation(s) of Fraud at issue;

2.3.6.5.2.2.1.3. The Contractor attests, in a form and format specified by EOHHS, that the fraud referral arose out of the Contractor's own investigatory activity that led to the identification of the allegation(s) of fraud at issue;

2.3.6.5.2.2.1.4. The Contractor complies with all other obligations in **Section 4.7.3**;

2.3.6.5.2.2.1.5. The Contractor made its Fraud referral to EOHHS prior to MFD's investigation becoming public knowledge; and

2.3.6.5.2.2.1.6. The basis of the Contractor's Fraud referral – the specific Provider and allegedly fraudulent conduct – is the subject of a verdict or settlement achieved by MFD with a Provider that requires the Provider to pay EOHHS.

2.3.6.5.2.2.2. The amount of the finders' fee performance incentive, as determined by EOHHS, shall be as set forth in **Section 4.7.3**.

2.3.6.5.2.3. The Contractor shall abide by and adhere to any release of liability regarding a provider in any verdict or settlement signed by MFD or EOHHS.

2.3.6.6. Other Program Integrity Requirements

2.3.6.6.1. Prior to initiating an audit, investigation, review, recoupment, or withhold, or involuntarily termination of a Provider, the Contractor shall request from EOHHS deconfliction, cease all activity, and wait to receive permission from EOHHS to proceed. The Contractor shall wait until EOHHS either grants the deconfliction request or notifies the Contractor to continue to cease activity so as not to interfere in a law enforcement investigation or other law enforcement activities.

2.3.6.6.2. The Contractor shall notify EOHHS within two business days after contact by the Medicaid Fraud Division, the Bureau of Special Investigations 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 Material Subcontractors, shall cooperate fully with the Medical Fraud Division, Bureau of Special Investigations, 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.

2.3.6.6.3. The Contractor shall report promptly to EOHHS, in accordance with **Appendix A** and all other Contract requirements, when it receives information about an Enrollee's circumstances that may affect their MassHealth eligibility, including but not limited to a change in the Enrollee's residence and the death of the Enrollee.

2.3.6.6.4. The Contractor shall report no later than five business days to EOHHS, in accordance with **Appendix A** and 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, including but not limited to the termination of the Provider's contract with the Contractor.

2.3.6.6.5. The Contractor shall verify, in accordance with other Contract requirements, through sampling, whether SCO Covered Services that were represented to be delivered by Providers were received by Enrollees. The Contractor shall report the identification of any overpayments related to SCO Covered Services that were represented to be delivered by Providers but not received by Enrollees in the following reports as set forth in **Appendix A: Fraud and Abuse Notification, Notification of Provider Overpayments, and Summary of Provider Overpayments report**.

2.3.6.6.6. The Contractor shall provide employees, as well as Material 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.

2.3.6.6.6.1. The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. §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.

2.3.6.6.6.2. If the Contractor is subject to such federal requirements, the Contractor shall:

2.3.6.6.6.2.1. On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in accordance with **Appendix A** or in another form acceptable to EOHHS, and signed under the pains and penalties of perjury, of compliance with such federal requirements;

2.3.6.6.6.2.2. Make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. §1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and

2.3.6.6.6.3. Failure to comply with this **Section 2.3.6.6** may result in intermediate sanctions in accordance with **Section 5.4**.

2.3.6.6.7. The Contractor shall designate a Fraud and Abuse prevention coordinator responsible for the following activities. Such coordinator may be the Contractor's compliance officer. The Fraud and Abuse prevention coordinator shall:

2.3.6.6.7.1. Assess and strengthen internal controls to ensure claims are submitted and payments properly made;

2.3.6.6.7.2. Develop and implement an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and Enrollee Fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

2.3.6.6.7.3. Conduct regular reviews and audits of operations to guard against Fraud and Abuse;

2.3.6.6.7.4. Receive 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;

2.3.6.6.7.5. Educate employees, Providers, and Enrollees about Fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per Mass. Gen. Laws Ch. 12, Section 5J;

2.3.6.6.7.6. Establish 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; and

2.3.6.6.8. In accordance with M.G.L. Ch. 12, Section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

2.3.6.6.9. 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;

2.3.6.6.10. Make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful or abusive actions by the Contractor, its parent organization, its Providers, or its Material Subcontractors;

2.3.6.6.11. Require Providers to implement timely corrective actions related to program integrity matters as approved by EOHHS or terminate Provider Contracts, as appropriate;

2.3.6.6.12. In accordance with **Appendix A**, submit a Summary of Provider Overpayments report in a form and format, and at times, specified by EOHHS, and submit ad hoc reports related to program integrity matters as needed or as requested by EOHHS; and

2.3.6.6.13. In accordance with **Appendix A**, have the CEO or CFO certify in writing to EOHHS that after a diligent inquiry, to the best of their knowledge and belief, the Contractor is in compliance with this Contract as it relates to program integrity requirements and has not been made aware of any instances of Fraud and Abuse other than those that have been reported by the Contractor in writing to EOHHS.

2.3.6.7. Screening Employees and Material Subcontractors

2.3.6.7.1. In addition to the requirements set forth in **Section 2.9.8**, the Contractor shall screen employees and Material Subcontractors by searching the Office of the Inspector General List of Excluded Individuals Entities and the other databases listed in **Appendix I** to determine if any such individuals or entities are excluded from participation in federal health care programs.

2.3.6.7.2. The Contractor shall conduct such screening upon initial hiring or contracting and on an ongoing monthly basis, or other frequency specified at **Appendix I**.

2.3.6.7.3. The Contractor shall notify EOHHS of any discovered exclusion of an employee or Material Subcontractor within two business days of discovery.

2.3.6.7.4. The Contractor shall require its Providers to also comply with the requirements of this **Section 2.3.6.7** with respect to its own employees and Material Subcontractors.

2.3.6.8. Screening Providers

2.3.6.8.1. The Contractor shall screen Providers in accordance with the requirements set forth in **Section 2.9.8**.

2.3.7. Continuity of Operations Plan

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

2.4. Eligibility, Enrollment, and Initial Outreach

2.4.1. Eligible Populations

2.4.1.1. To be eligible to enroll in SCO, an individual shall:

2.4.1.1.1. Be 65 years of age or over or be turning 65 years of age during the month in which the SCO enrollment would first be effective;

2.4.1.1.2. Reside in the Commonwealth;

2.4.1.1.3. Be enrolled in Medicare Parts A and B and eligible for Part D;

2.4.1.1.4. Be enrolled in MassHealth Standard;

2.4.1.1.5. Have no other comprehensive private or public health insurance;

2.4.1.1.6. Not have presumptive eligibility;

2.4.1.1.7. Not be subject to a six-month deductible period under 130 CMR 520.028;

2.4.1.1.8. Not be a refugee described at 130 CMR 522.002;

2.4.1.1.9. Not be enrolled in a home and community-based services waiver other than the Frail Elder Waiver as described in 130 CMR 519.007(B). Otherwise, individuals eligible for or participating in the Frail Elder Waiver may be enrolled with the Contractor, provided they meet the requirements of **Section 2.4.1**; and

2.4.1.1.10. Not be excluded on the SCO Effective Enrollment Date for any reason described in **Section 2.4.2**.

2.4.2. Concurrent Exclusion Reasons

2.4.2.1. Individuals residing in an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services (DDS) may not be enrolled in SCO.

2.4.2.2. Individuals enrolled in HCBS waivers other than the Frail Elder Waiver who meet the eligibility criteria for SCO may enroll in a SCO Plan, with SCO enrollment taking effect on the first day of the first month following the individual's disenrollment from such HCBS waiver.

2.4.2.3. Individuals enrolled in PACE, another Medicare Advantage Plan, or a Medicare Part D Plan may enroll in a SCO Plan, with SCO enrollment taking effect on the first day of the first month following the individual's disenrollment from their PACE, Medicare Advantage, or Part D Plan.

2.4.3. Eligibility Verification

2.4.3.1. Prior to submitting an enrollment to EOHHS, the Contractor shall verify through EOHHS's electronic online Eligibility Verification System (EVS) that the MassHealth Member is enrolled in MassHealth Standard, and

otherwise meets SCO participation requirements as described in **Section 2.4.1**.

2.4.3.2. If the Enrollee is covered under a different comprehensive healthcare product, including those operated by the Contractor (including commercial plans, and Qualified Health Plans offered through the Exchange), the Contractor shall promptly submit to EOHHS a completed Third-Party Liability (TPL) Indicator Form in accordance with EOHHS's specifications.

2.4.3.3. The Contractor shall instruct and assist the Contractor's Providers in the process and need for verifying an Enrollee's MassHealth eligibility and enrollment prior to providing any service at each point of service, through EOHHS's Eligibility Verification System (EVS), provided, however, the Contractor and its Providers shall not require such verification prior to providing Emergency Services.

2.4.4. Eligibility and Enrollment Resources

2.4.4.1. The Contractor shall direct all inquiries about MassHealth eligibility coverage that the Contractor may receive from Enrollees or their representatives, as well as former or prospective Enrollees and their representatives, to the MassHealth customer service vendor as applicable. For inquiries received by phone, the Contractor shall make best efforts to connect the caller to the MassHealth customer service line. For eligibility- related inquiries the Contractor may receive through other media, or when the MassHealth customer service vendor is unreachable, the Contractor shall offer to connect the individual at another time, and/or otherwise assist the individual to successfully reach the MassHealth customer service line within a reasonable period of time. The Contractor shall document all measures the Contractor took to address the eligibility-related inquiries, including their efforts to connect the caller to the MassHealth customer service line. The Contractor shall make this information available to EOHHS upon request.

2.4.4.2. The Contractor shall direct all requests for individual Medicare insurance information, counseling, and assistance to the SHINE (Serving the Health Insurance Needs of Everyone) Program, the Massachusetts State Health Insurance Assistance Program (SHIP), SHINE is a free, nonbiased resource for individuals to understand the insurance options available to them, or to 1-800-Medicare.

2.4.4.3. The Contractor shall provide EOHHS with access to enrollment packages, Marketing materials, and educational materials to use as training materials and reference guides about SCO and the Contractor's Plan, and to be distributed by EOHHS's customer service vendor to Members upon request by EOHHS.

2.4.5. MassHealth Benefit Request and Eligibility Redetermination Assistance

2.4.5.1. The Contractor shall:

2.4.5.1.1. Actively track redetermination due dates, including with information provided by EOHHS;

2.4.5.1.2. No later than thirty (30) days prior to the Enrollee's MassHealth redetermination date, contact the Enrollee and provide assistance (if required) to complete and return to MassHealth the redetermination form;

2.4.5.1.3. Assertively support Enrollees to resolve redetermination requests with EOHHS;

2.4.5.1.4. Make best efforts to proactively assist Enrollees to remain continuously enrolled in their SCO Plan when they are likely to be found eligible through a redetermination process;

2.4.5.1.5. Make best efforts to help Enrollees avoid lapses in their MassHealth eligibility; and

2.4.5.1.6. Communicate with Enrollees to help them renew their MassHealth coverage. The Contractor is authorized and directed to make appropriate use of prerecorded or artificial autodialed calls and automated texts in compliance with the Federal Communications Commission January 23, 2023, Declaratory Ruling. The Contractor shall consult its legal counsel about the appropriate use of autodialed calls and automated texts to Enrollees pursuant to the FCC Declaratory Ruling. The Contractor shall be responsible for complying with the ruling.

2.4.5.1.7. The Contractor shall assist Enrollees with completing eligibility redetermination activities as follows. The Contractor shall:

2.4.5.1.7.1. Explain to Enrollees the forms used to apply for MassHealth Benefits (e.g., ACA-3, SACA-2);

2.4.5.1.7.2. Assist MassHealth applicants in applying for MassHealth, including support completing and submitting MassHealth forms;

2.4.5.1.7.3. Provide assistance to Enrollees with the completion of the annual Eligibility Redetermination Verification form and other MassHealth Eligibility forms, including assistance with completing and submitting MassHealth forms, gathering necessary documentation, and addressing logistical barriers; and

2.4.5.1.7.4. Refer Enrollees to the MassHealth customer service center as needed or to other specific resources as directed by EOHHS.

2.4.6. Enrollment

2.4.6.1. Enrollment Processing

2.4.6.1.1. Enrollment and disenrollment shall be processed through the SCO Plan, consistent with the Effective Enrollment Date requirements outlined in **Section 2.4.6.2**, and the requirements for marketing, education, and enrollment activities described in **Section 2.12.1**.

2.4.6.1.2. At EOHHS's discretion, EOHHS may require the Contractor to opt into the Medicare Online Enrollment Center (OEC) to receive Medicare Enrollment and Disenrollment requests for its SCO Plan; upon such direction from EOHHS, the Contractor shall opt in and maintain participation in the OEC throughout the Contract Term.

2.4.6.1.3. The Contractor shall:

2.4.6.1.3.1. Have a mechanism for sending and receiving timely information about all Enrollees, including confirmation of the Effective Enrollment Date, from CMS and MassHealth systems;

2.4.6.1.3.2. Submit enrollment requests to EOHHS via the Provider Online Service Center on behalf of MassHealth Members eligible for, and seeking to enroll in, the Contractor's SCO Plan;

2.4.6.1.3.3. Submit and receive aligned enrollment transactions to CMS or its designee for Medicare coverage through the Contractor's SCO Plan, in accordance with CMS requirements;

2.4.6.1.3.4. Maintain aligned Medicare and Medicaid enrollments in the Contractor's SCO Plan.

2.4.6.1.3.5. On each business day, obtain from EOHHS, the daily and monthly (as available) via the HIPAA 834 Enrollment Files, and process information pertaining to all enrollments in the Contractor's Plan, including the Effective Date of Enrollment;

2.4.6.1.3.6. The Contractor's internal enrollment system shall be configured to automatically ingest these files and use them for the following purposes:

2.4.6.1.3.6.1. **Enrollment and Disenrollment Tracking**: Monitor and confirm all member enrollments and disenrollments as provided in the 834 files;

2.4.6.1.3.6.2. **Aid Category Changes**: Accurately track any changes in member aid categories as reported in the files;

2.4.6.1.3.6.3. **Disenrollment Date Calculation**: Calculate the appropriate disenrollment date when a member's aid category change necessitates disenrollment from the plan. The calculated disenrollment date must comply with the advance notice requirements described in this Contract and in Medicare Enrollment Guidelines; and

2.4.6.1.3.6.4. **Demographic Changes**: Track and update any member demographic changes as provided in the HIPAA 834 Enrollment Files.

2.4.6.2. Enrollment Policy

2.4.6.2.1. General

2.4.6.2.1.1. Enrollment in SCO is voluntary. The first Effective Enrollment Date under this Contract is scheduled for no earlier than January 1, 2026.

2.4.6.2.1.2. The Contractor shall submit clinical assessment information (MDS-HC or its successor, or MDS 3.0, as described in **Section 2.6**) to EOHHS to assign an Enrollee to a Rating Category.

2.4.6.2.1.3. Enrollments received, approved, processed, and confirmed 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.

2.4.6.2.1.4. The Contractor shall be responsible to provide or arrange, and to pay for all SCO Covered Services required to be provided by the Contractor to Enrollees under this Contract for each Enrollee as of 12:01 a.m. on the Effective Enrollment Date for the Enrollee, even if the Contractor is not notified of an Enrollee's enrollment into the Contractor's SCO Plan until after such Enrollee's Effective Enrollment Date. As specified by EOHHS, the Contractor's responsibilities under this Section continue until such time as provided in **Section 2.4.3**.

2.4.6.2.1.5. Enrollment in the Contractor's Plan shall occur at the sole discretion of the Member or EOHHS, except for Reinstatement as described in **Section 2.4.7**, to ensure Exclusively Aligned Enrollment as required in **Section 2.4.10**, or as described in **Section 2.4.9**.

2.4.6.2.1.6. Subject to the eligibility requirements set forth in 130 CMR 508 et seq. and in **Section 2.4.1**. above, the Contractor shall accept for enrollment all eligible MassHealth Members seeking enrollment in the order in which they seek to join the Contractor's Plan or are assigned to the Contractor's Plan, without restriction.

2.4.6.2.1.7. The Contractor shall notify EOHHS of any third-party liability in accordance with **Section 2.17.8.1**.

2.4.6.2.1.8. The Contractor shall inform the Member that enrolling in SCO ends the Member's enrollment in their current PACE, a Medicare Advantage Plan that is not a SCO Plan, or a Medicare Part D Plan, prior to the effective date of their SCO Plan enrollment.

2.4.6.2.1.9. The Contractor shall accept for enrollment in the Contractor's Plan all eligible MassHealth Members seeking enrollment at any time without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, or sensory disabilities as further defined by EOHHS), age, sex, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for Covered Services.

2.4.6.2.1.10. The Contractor shall not interfere with the Enrollee's right to enroll or remain enrolled in its SCO Plan through threat, intimidation, pressure, or otherwise.

2.4.6.2.2. Member Consent

2.4.6.2.2.1. The Contractor shall utilize integrated enrollment forms, modalities, and methods permitted pursuant 42 CFR 422 subpart V, to the Medicare Communication and Marketing Guidance and approved by EOHHS.

2.4.6.2.2.2. The Contractor shall provide a range of methods (e.g., electronic submission, paper form submission, telephonic with signature, etc.) accessible to individuals with various disabilities, functional needs, and accessibility needs for

Members to use to Enroll into or Disenroll from the Contractor’s SCO Plan.

2.4.6.2.2.3. The Contractor shall establish and execute policies and procedures that provide mechanisms by which an Enrollee or Authorized Representative can sign or otherwise convey agreement (i.e., recorded verbal consent) to Enroll in and Disenroll from the Contractor’s SCO Plan.

2.4.6.2.2.4. The Contractor shall accept requests to Enroll in or Disenroll from the Contractor’s SCO Plan from the MassHealth Member or their Authorized Representative via telephone, but shall confirm Member consent by obtaining the Member's, or their Authorized Representative’s, signature on an enrollment or disenrollment form, including an electronic form. The Contractor may use alternative means of consent only for Members who are not able to provide a signature as an accessibility accommodation.

2.4.6.2.2.5. Only the MassHealth Member or their Authorized Representative may make voluntary Enrollment or Disenrollment decisions and provide authorization (i.e., consent) for such actions.

2.4.6.2.2.6. The Contractor shall document Member consent to enroll into or disenroll from SCO in accordance with all applicable rules and guidance and as further directed by EOHHS.

2.4.6.2.2.7. The Contractor shall maintain records of all such Member consent and provide such records to EOHHS for review upon request.

2.4.7. Reinstatement

2.4.7.1. RESERVED.

2.4.8. Deemed Eligibility

2.4.8.1. The Contractor shall provide Medicare continued Deemed Eligibility for no less than thirty (30) days from the issue date of the required advance notice of Medicare disenrollment from the D-SNP due to loss of special needs status, as required by 42 CFR 422.52(d) and Chapter 2 of the Medicare Managed Care Manual.

2.4.8.2. Medicare Covered Services and enrollment shall extend through the last day of the calendar month of the required Deemed Eligibility period, and shall not be cancelled retroactively, unless approved by EOHHS.

2.4.8.3. During the Deemed Eligibility period, the Contractor shall continue to provide continued Medicare enrollment and coverage through the Contractor's SCO D-SNP as described in this **Section 2.4.8**, concurrent with Medicaid enrollment and coverage as described in **Section 2.4.12** through the Contractor's SCO Medicaid managed care organization.

2.4.8.4. The Contractor shall make best efforts to maintain aligned Medicare and Medicaid enrollment periods and shall provide concurrent Medicare and Medicaid coverage (to the extent Medicaid coverage is available per **Section 2.4.12**) for Enrollees during any Medicare Deemed Eligibility period.

2.4.9. Default Enrollment

2.4.9.1. The Contractor shall request and subsequently receive EOHHS's advance approval in writing prior to using the Default Enrollment process established by CMS in 42 CFR §§ 422.66(c), 422.68(a), and Section 40.1.5 of the Medicare Advantage and Part D Enrollment and Disenrollment Guidance. EOHHS may revoke its approval for a Contractor to conduct Default Enrollment at any time.

2.4.10. FIDE SNP Exclusively Aligned Enrollment in MassHealth and Medicare Coverage

2.4.10.1. In accordance with **Section 2.1**, prior to commencing the initial enrollment of MassHealth Members, the Contractor shall 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 each county approved by EOHHS to be served by the Contractor under this Contract.

2.4.10.2. The Contractor shall operate a SCO Plan that meets the requirements of a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), and shall provide Exclusively Aligned Enrollment for Dual Eligible individuals as follows:

2.4.10.2.1. Eligible individuals choosing to participate in SCO shall enroll for both their Medicare and their MassHealth coverage through a single SCO Plan, and

2.4.10.2.2. Dual Eligible individuals may not be enrolled in a SCO Plan for only their Medicare or their MassHealth coverage.

2.4.10.3. Individuals enrolled in Medicare but not eligible for MassHealth Standard are not eligible to enroll in SCO, including in the Contractor's SCO D-SNP for their Medicare coverage.

2.4.10.4. The Contractor shall conduct enrollments and disenrollments for Dual Eligible individuals to always ensure the individual's MassHealth and Medicare enrollments are aligned and maintained with the same SCO Plan.

2.4.10.5. The legal entity holding a contract with CMS for the FIDE SNP covered under this Contract receives direct capitation from EOHHS to provide coverage of the Medicaid benefits described in **Appendix C**.

2.4.10.6. In an instance when an individual's Effective Enrollment Date is later than the first calendar day of the following month, the Contractor shall hold the Medicaid enrollment or disenrollment transaction and shall submit it to MMIS no sooner than the first day of the month preceding the Effective Enrollment Date of the Medicare enrollment. The Contractor shall make best efforts to ensure MassHealth and Medicare enrollment effective dates remain aligned.

2.4.11. Limiting or Suspending Enrollment

2.4.11.1. The Contractor shall accept new enrollments as described in **Section 2.4.6** unless, with at least thirty (30) calendar days advance notice, the Contractor requests and receives EOHHS' approval to limit enrollment for a predetermined amount of time, including in accordance with 42 CFR 422.60;

2.4.11.2. EOHHS may require the Contractor to suspend new Medicaid enrollments within six (6) months (or less) of the end date of the Contract, unless the Contract is or is expected to be renewed or extended.

2.4.11.3. EOHHS may require the Contractor to suspend enrollment as described in **Section 5.4**.

2.4.12. Disenrollment

2.4.12.1. Disenrollment Processing

2.4.12.1.1. The Contractor shall:

2.4.12.1.1.1. Have a mechanism for sending and receiving timely information about all disenrollments from the Contractor's SCO Plan, including the effective date of disenrollment and the disenrollment reason code from CMS and MassHealth systems.

2.4.12.1.1.2. Submit Disenrollment transactions and reason codes to EOHHS on behalf of Enrollees seeking to disenroll from the Contractor's SCO Plan.

2.4.12.1.1.3. Submit and receive aligned disenrollment transactions to CMS or its designee to disenroll from Medicare coverage through the Contractor's SCO Plan, in accordance with CMS requirements.

2.4.12.1.1.4. On each business day, obtain the HIPAA 834 Enrollment File from EOHHS and process information pertaining to all Enrollee disenrollments, including the Effective Date of Disenrollment and disenrollment reason code.

2.4.12.1.1.5. At a minimum, continue to provide SCO Covered Services, and all other services required under this Contract, to Enrollees through 11:59 p.m. on the Effective Date of Disenrollment, and be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment, as specified by EOHHS.

2.4.12.1.1.6. EOHHS shall review the Contractor's voluntary disenrollment rate, including as compared with other SCO Plans and other MassHealth FIDE SNPs, as an indicator of plan performance towards meeting Enrollee satisfaction.

2.4.12.2. Disenrollment Policy

2.4.12.2.1. General

2.4.12.2.1.1. Disenrollments received by the Contractor and approved by EOHHS and CMS by the last business day of the month will be effective on the first calendar day of the following month,

2.4.12.2.1.2. For all disenrollments, the Contractor shall have processes in place to ensure continuity of services and to cooperate with EOHHS in the smooth transition of a disenrolled beneficiary to their subsequent Medicaid and/or Medicare coverage.

2.4.12.2.1.3. If the Enrollee transfers to another SCO Plan or PACE, the Contractor shall, with the Enrollee's written consent, in accordance with applicable laws and regulations, promptly transfer current Minimum Data Set Home Care (MDS-HC) assessment (or successor tool, if applicable) information to the new MassHealth Plan; and

2.4.12.2.1.4. The Contractor shall:

2.4.12.2.1.4.1. Not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise,

2.4.12.2.1.4.2. Not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their individual needs (except when the Enrollee's continued enrollment in the SCO Plan seriously impairs the SCO Plan's ability to furnish services to either the particular enrollee or other enrollees),

2.4.12.2.1.4.3. Transfer Enrollee record information promptly to the new provider upon written request signed by the disenrolled Enrollee,

2.4.12.2.1.4.4. Notify EOHHS if the Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

2.4.12.3. Voluntary Disenrollment

2.4.12.3.1. Subject to 42 C.F.R. § 422.66 and § 438.56, and subject to applicable eligibility requirements, Enrollees may elect to disenroll from their SCO Plan and enroll in a different SCO Plan, or another MassHealth program such as PACE, or to enroll in MassHealth FFS or other MassHealth State plan and/or waiver programs and either Original Medicare (FFS) or a Medicare Advantage Plan, including enrollment into a Part D Plan.

2.4.12.3.2. When an Enrollee meets participation requirements for their current SCO Plan but elects to enroll in a different Plan for their Medicaid coverage, Medicare coverage, or both, the disenrollment shall be considered voluntary.

2.4.12.3.3. All voluntary disenrollments shall meet the Member Consent requirements of **Section 2.4.6.2.2** above.

2.4.12.3.4. The Contractor shall document the Enrollee's reason for voluntary disenrollment and shall report to EOHHS such reasons in a form and format specified by EOHHS.

2.4.12.3.5. 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.

2.4.12.4. Qualifying Involuntary Disenrollment

2.4.12.4.1. The Contractor may request that an Enrollee be involuntarily disenrolled for the following reasons only:

2.4.12.4.1.1. Loss or downgrade of MassHealth eligibility;

2.4.12.4.1.2. Enrollee no longer meets SCO program participation requirements set forth in **Section 2.4.1**;

2.4.12.4.1.3. Enrollee has confirmed to the Contractor that they have relocated out of the Service Area;

2.4.12.4.1.4. Fraud or abuse, which occurs when the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.4.12.4.2. Consistent with the requirements of **Appendix M**, the Contractor may submit a written request, accompanied by supporting documentation, to EOHHS to disenroll an Enrollee, for cause, for the following reason:

2.4.12.4.2.1. When the Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their individual needs. Such requests shall be approved by EOHHS in advance, and the Contractor shall follow the procedures described in **Appendix M**.

2.4.12.4.3. For Involuntary Disenrollments related to MassHealth eligibility changes:

2.4.12.4.3.1. Medicare Enrollment continues as described in **Section 2.4.8**; and

2.4.12.4.3.2. Medicaid Enrollment continues until the last day of the month during which the Enrollee's last Medicaid eligible day occurs.

2.4.13. Initial Enrollee Contact and Onboarding

2.4.13.1. The Contractor shall:

2.4.13.1.1. Except as otherwise permitted during Medicare open enrollment, provide an onboarding to Enrollees within thirty (30) days, either prior to or following the initial date of enrollment. The onboarding shall include:

2.4.13.1.1.1. Engage with the Enrollee to identify any immediate health or social needs (e.g., immediately connecting an Enrollee with a dentist for urgent dental needs); and

2.4.13.1.1.2. Working with the Enrollee to schedule a Comprehensive Assessment (see **Section 2.5**);

2.4.13.2. Selection of a Primary Care Provider (PCP);

2.4.13.2.1. For Enrollees with a current non-network Primary Care Provider (PCP), making reasonable efforts to contract with their PCP (See **Section 2.8.3**);

2.4.13.2.2. For Enrollees with a current PCP that is not in network and refuses to become a Network Provider or enter into a single case non-network agreement where applicable (see **Section 2.8.2.2**), assist the Enrollee to choose a PCP. The Enrollee shall choose a new PCP by the end of the 90-day Continuity of Care period or after the Individualized Care Plan is developed. If the Enrollee has not chosen an in-network PCP by that time, the Contractor shall choose one for the Enrollee;

2.4.13.2.3. For Enrollees without a current PCP identified at the time of enrollment, the Contractor shall assist the Enrollee to identify and choose a PCP with an open panel; and

2.4.13.2.4. If an Enrollee does not identify a current PCP or select a PCP within ninety (90) days of enrollment, and the Contractor has made reasonable, unsuccessful attempts to engage the Enrollee in identifying or selecting a PCP, the Contractor shall assign a PCP to the Enrollee and notify the Enrollee of the assignment;

2.4.13.2.5. Provide materials, including those described in **Section 2.12.5**, and a welcome call to the Enrollee including, but not limited to the following:

2.4.13.2.5.1. Providing any pre-enrollment materials specified in **Section 2.4** that, due to a late month enrollment request, were not provided prior to the time of enrollment;

2.4.13.2.5.2. Making available any enrollment and onboarding materials upon request and with consent of the Enrollee to family members, significant informal caregivers, and designated representatives, as appropriate; and

2.4.13.2.5.3. For Enrollees for whom written materials are not appropriate, providing non-written onboarding in a format such as telephone calls, home visits, video screenings, or group presentations.

2.4.13.3. Notify its Enrollees:

2.4.13.3.1. That translations of written information are available in Prevalent Languages per 42 CFR 422.2267(a);

2.4.13.3.2. That oral interpretation services are available for any language spoken by Enrollees and Eligible Individuals free of charge;

2.4.13.3.3. How Enrollees can access oral interpretation services;

2.4.13.3.4. How Enrollees can access alternate format materials described in **Section 2.12.3**; and

2.4.13.3.5. How Enrollees can make a standing request to receive all future notifications and communication in a specified preferred language and/or Alternative Format per 42 CFR 422.2267(a).

2.4.13.3.6. Ensure that all onboarding materials are provided in a manner and format that may be easily understood, including providing written materials in Prevalent Languages and oral interpretation services when requested.

2.5. Assessments and Care Plans

2.5.1. Comprehensive Assessment

2.5.1.1. Frequency of Assessments

2.5.1.1.1. At Enrollment

2.5.1.1.1.1. The Contractor shall complete a Comprehensive Assessment within thirty (30) calendar days of each Enrollee's Effective Enrollment Date.

2.5.1.1.1.2. The Contractor shall make subsequent attempts beyond the thirty (30) days if the initial attempt to contact the Enrollee is unsuccessful. The Contractor shall incorporate the following into their policies and procedures for unreachable Enrollees:

2.5.1.1.1.2.1. The Contractor shall submit a weekly no contact list to EOHHS outlining frequency and type of outreach efforts,

2.5.1.1.1.2.2. The Contractor's Medical Director or designee shall review past and/or current claims utilization to find provider(s) and/or pharmacies connected to the Enrollee, and

2.5.1.1.1.2.3. The Contractor shall notify EOHHS of Enrollees who remain unreachable after 180 days, have not actively participated in Care Coordination, Assessment and Care Planning, and who have no claims for physical and/or behavioral health treatment.

2.5.1.1.1.3. With the Member's consent, the Contractor may complete the assessment in advance of the Effective Enrollment Date for new SCO program Enrollees.

2.5.1.1.1.4. The Contractor is not required to conduct a new Comprehensive Assessment for individuals who were enrolled in the Contractor's SCO Plan prior to January 1, 2026, and for whom that Comprehensive Assessment is still current in accordance with **Section 2.5.1.1.2.1**.

2.5.1.1.2. Ongoing

2.5.1.1.2.1. The Contractor shall complete Comprehensive Assessments for all Enrollees to identify all of an Enrollee's needs, and to evaluate and identify Complex Care needs:

2.5.1.1.2.1.1. For all Enrollees, at least once every six months;

2.5.1.1.2.1.2. At least quarterly for Enrollees who require Complex Care;

2.5.1.1.2.1.3. More frequently when indicated by the condition identified; or

2.5.1.1.2.1.4. Whenever an Enrollee experiences a major change that is:

2.5.1.1.2.1.4.1. Not temporary or episodic;

2.5.1.1.2.1.4.2. Impacts more than one area of health status; and

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

2.5.1.2. Approach

2.5.1.2.1. General

2.5.1.2.1.1. The Contractor shall perform Comprehensive Assessments for all Enrollees to collect pertinent medical and behavioral health history, and support needs to begin the development of an Enrollee's Individualized Care Plan.

2.5.1.2.1.2. The Enrollee shall be at the center of the Comprehensive Assessment process. The Contractor shall ensure that the Enrollee receives information about the Comprehensive Assessment, and any necessary assistance and accommodations to prepare for and fully participate in the Comprehensive Assessment, the right to initiate Service Requests, and how to request access to the Comprehensive Assessment results and documentation.

2.5.1.2.1.3. This assessment shall be conducted by a Registered Nurse or equivalently trained professional. In performing these assessments, the Contractor shall also comply with 42 CFR 438.208(c)(2) through (4) and M.G.L. c. 118E, § 9D(h)(3).

2.5.1.2.1.4. The Contractor shall record the findings of the Comprehensive Assessment results, which includes but is not limited to all pertinent Enrollee reported information in the Centralized Enrollee Record.

2.5.1.2.2. Concurrent Assessment Requirements

2.5.1.2.2.1. At least annually, the Comprehensive Assessment described in **Section 2.5.1** shall be conducted concurrently with the assessment for Rating Category assignment (i.e., MDS-HC or its successor), as described in **Section 2.5.2**, to remove redundancies in the assessment process and to reduce burden on the Enrollee.

2.5.1.2.2.2. Any elements required in both assessments shall be completed by a qualified Registered Nurse as described in **Section 2.5.2.2.1**.

2.5.1.2.2.3. Other elements specific to the Comprehensive Assessment may be completed by a non-RN GSSC or by the Contractor.

2.5.1.2.3. In-person/Face-to-Face Requirements

2.5.1.2.3.1. In-person and in the Enrollee's, home shall be the default for conducting all Comprehensive Assessments.

2.5.1.2.3.2. Subject to advance approval by EOHHS, the Contractor may have policies and procedures to use modalities other than in-person engagement (e.g., virtually with audio and video, or other alternatives approved by EOHHS) for Comprehensive Assessments in certain cases, based on a particular Enrollee's need and current status.

2.5.1.2.3.3. The Contractor shall not have policies or procedures that rely on alternative modalities based on geographic location, travel time for an assessor, use of contracted vendors or staff not primarily located within Massachusetts, or to reduce costs.

2.5.1.2.3.4. Assessments for the purpose of assigning a Rating Category (e.g., MDS-HC or its successor) shall be administered in-person.

2.5.1.2.3.5. Assessments for Enrollees requiring Complex Care shall occur in person.

2.5.1.2.4. Assessor Qualifications

2.5.1.2.4.1. For SCO Enrollees requiring Complex Care, the Assessments shall be conducted in person by a Registered Nurse; and

2.5.1.2.4.2. For all other SCO Enrollees, the Comprehensive Assessment shall be conducted by a Registered Nurse (RN) or equivalently trained health professional, or by a GSSC, as indicated in **Section 2.6.1.2.2**. An equivalently trained health care professional is an individual with training inclusive of or substantially similar to the training provided to an RN.

2.5.1.2.5. Comprehensive Assessment Tool

2.5.1.2.5.1. The Comprehensive Assessment shall be conducted using an approved assessment tool and informed by at least one (1) in-person meeting with the Enrollee. The tool shall include all required domains in **Section 2.5.1.2.6** and shall also cover expanded domains as may be relevant for each Enrollee to creation of their ICP.

2.5.1.2.5.2. The Contractor may develop its own tool to conduct the Comprehensive Assessment. All assessment tools shall be prior approved by EOHHS,

2.5.1.2.5.3. EOHHS reserves the right to specify which tool the Contractor shall use to conduct the Comprehensive Assessment.

2.5.1.2.5.4. Any changes the Contractor proposes to make to its Comprehensive Assessment tool shall be approved by EOHHS prior to use.

2.5.1.2.6. Required Domains

2.5.1.2.6.1. The Comprehensive Assessment tool and process shall include the following domains, which may be updated by EOHHS during the Contract period:

2.5.1.2.6.2. Enrollee's description of their immediate needs, problems, or conditions using the Enrollee's own voice;

2.5.1.2.6.3. A face-to-face evaluation of the Enrollee's clinical status, functional status, cognitive status, nutritional status, oral health, home environment, and physical well-being;

2.5.1.2.6.4. A screening for Enrollee Behavioral Health needs, including for mental health and for substance use or misuse;

2.5.1.2.6.5. An assessment of the Enrollee's functional status, including ADL and IADL limitations and support needs, the Enrollee's need for Long-term Services and Supports, and of the availability of and Enrollee's preferences regarding informal supports, services, caregivers, Privacy, and daily routines;

2.5.1.2.6.6. Status of and access to preventive care, screenings, immunizations/vaccines, and wellness strategies, including for oral health, sexual and reproductive health and family planning, nutritional needs, exercise/activity, and other prevention strategies;

2.5.1.2.6.7. Screening for health conditions, cognitive changes, changing functional status and needs, and other areas of health and wellness that present or advance as part of aging;

2.5.1.2.6.8. An assessment to identify any abuse, neglect, and exploitation of the Enrollee, including present or potential risks,

2.5.1.2.6.9. An assessment of the Enrollee's housing status and environmental safety risks and adaptive modification needs, including the Enrollee's risk of falling;

2.5.1.2.6.10. A review of the Enrollee's current medications for all health conditions, including the Enrollee's ability to manage medications, including obtaining, organizing, and self-administering medications, and any supports necessary;

2.5.1.2.6.11. An assessment of specific communication needs, preferences, and accommodations, such as preferred language and preferred method of communication, language interpreters/translators, sign language interpreters, CART,

written materials, and any other adaptations and supports necessary for the Enrollee to understand treatment options;

2.5.1.2.6.12. Race, Ethnicity, Language, Sexual Orientation, and Gender Identification (REL SOGI), including identifying how these factors create barriers to or otherwise influence the Enrollee's needs, problems, conditions, and access to care;

2.5.1.2.6.13. An assessment of social needs and Social Determinants of Health, including transportation, housing, food security, social isolation/connections, community participation, work/vocational, financial security, and interpersonal factors;

2.5.1.2.6.14. Cultural and ethnic orientation or personal beliefs towards the Enrollee's presenting concerns that may influence the Enrollee's preferences for their care; and

2.5.1.2.6.15. Advance Directive/guardianship, authorized representatives, including health care proxy and power of attorney.

2.5.2. Assessment for Assignment to Rating Categories

2.5.2.1. General

2.5.2.1.1. For all Enrollees residing in the community, the Contractor shall complete and submit assessments as instructed by EOHHS to inform EOHHS's assignment of Enrollees to community Rating Categories and capitation payment.

2.5.2.1.2. For certain individuals, this assessment shall also be used to verify clinical eligibility for the Frail Elder Waiver.

2.5.2.1.3. The Contractor shall use the MDS-HC (or its successor) as the assessment tool designated by EOHHS for Rating Category assignment, as instructed by EOHHS, and as further described in **Section 2.5.2**.

2.5.2.1.4. The MDS-HC assessment shall be completed in person with the Enrollee, in the Enrollee's residence.

2.5.2.1.5. The MDS-HC assessment shall be completed for Enrollees in the community, including the default (lowest acuity) community Rating Category, as provided for below.

2.5.2.2. Assessor Qualifications

2.5.2.2.1. The MDS-HC assessment shall be completed in-person with the Enrollee by a Registered Nurse. The Contractor shall verify licensures for all RNs conducting MDS-HC assessments at least monthly (as required in **Section 2.5.1**).

2.5.2.2.2. The MDS-HC assessment shall be conducted concurrently with and incorporated into the Comprehensive Assessment whenever both are due. When conducting the assessments concurrently, the process may be streamlined to avoid duplicative questions. Responses to Comprehensive Assessment elements may be applied to the MDS-HC, other than for assessing functional status, as long as the assessor meets the qualifications required for the MDS-HC assessment (see **Section 2.5.2.2**).

2.5.2.2.3. The assessor may obtain additional information about Enrollees from other sources including Case Managers, health care providers, a Geriatric Support Services Coordinator (GSSC) from an ASAP, and Enrollee medical records.

2.5.2.2.4. The Contractor shall cooperate with and participate in any and all requests from EOHHS for further information concerning any submitted MDS-HC assessment data or related information.

2.5.2.3. Frequency

2.5.2.3.1. At Enrollment

2.5.2.3.1.1. The Contractor shall conduct a new MDS-HC assessment whenever an individual enrolls in the Contractor's SCO plan, including for Enrollees transferring from another SCO plan.

2.5.2.3.1.2. Within thirty (30) days of each Enrollee's Effective Enrollment Date into the Contractor's SCO plan, the Contractor shall submit to EOHHS a completed MDS-HC assessment. With the Member's consent, the Contractor may complete the assessment in advance of the Effective Enrollment Date for incoming SCO program Enrollees.

2.5.2.3.1.3. For Enrollees participating in the Frail Elder Waiver, the MDS-HC assessment conducted at Enrollment shall be completed by the ASAP RN.

2.5.2.3.1.4. An MDS-HC assessment conducted for a new Enrollee shall be designated as an "initial assessment" upon submission.

2.5.2.3.2. Ongoing

2.5.2.3.2.1. For all Enrollees assigned to a community Rating Category, including the default (lowest) Rating Category, the Contractor shall complete the Rating Category assessment at least annually.

2.5.2.3.2.2. MDS-HC assessments conducted after the assessment at the time of Enrollment shall be completed by a qualified Registered Nurse employed by the Contractor's SCO plan.

2.5.2.3.2.3. For Enrollees participating in the Frail Elder Waiver, the MDS-HC assessment shall be completed no later than 365 calendar days from the previous MDS-HC completion date.

2.5.2.3.2.4. An MDS-HC assessment conducted to meet the annual frequency requirement shall be designated as an "annual assessment" upon submission.

2.5.2.3.2.5. At any time, when an Enrollee has a significant change in status, the Contractor shall complete and submit a new Rating Category assessment to EOHHS. An MDS-HC assessment conducted under this circumstance shall be designated as a "change in status assessment" upon submission.

2.5.2.3.2.6. For an individual who is re-enrolling in the Contractor's SCO plan within six (6) months of the date of their last completed MDS-HC assessment, the Contractor may consider their last completed MDS-HC assessment valid for purposes of meeting the ongoing assessment requirements of this **Section 2.5.2.3.2**.

2.5.2.4. Submission

2.5.2.4.1. Information collected on the MDS-HC or its successor shall be collected and submitted for all Enrollees to EOHHS via the MDS-HC application in the Commonwealth's Virtual Gateway to ensure accurate assignment of Rating Categories, and may be used to inform risk adjustment.

2.5.2.4.2. The Contractor shall cooperate with and participate in any and all requests made by EOHHS for further information concerning any MDS-HC submission.

2.5.2.4.3. EOHHS reserves the right to make changes to this tool in the future.

2.5.2.5. MassHealth Review

2.5.2.5.1. The Contractor shall have policies and procedures in place to submit Rating Category discrepancies to EOHHS for review.

2.5.2.5.2. EOHHS may audit the Contractor's assessment processes and tools at any time, including through case file and medical record review.

2.5.2.6. Enrollees in Facility Settings

2.5.2.6.1. Status Change Form (SC-1)

2.5.2.6.1.1. EOHHS uses the EOHHS Status Change form ("SC-1") to identify and designate the start and end dates for payment to a long-term care facility. In SCO, the SC-1 form also identifies an Enrollee as residing in a Nursing Facility or in the Community (upon discharge) for Rating Category assignment.

2.5.2.6.1.2. The SC-1 form shall be completed and submitted to EOHHS:

2.5.2.6.1.2.1. Upon an Enrollee's admission to or discharge from a Nursing Facility; and

2.5.2.6.1.2.2. In the event of a facility closure, which shall be considered a discharge from the facility for payment and Rating Category assignment purposes.

2.5.2.6.1.3. SC-1 forms are submitted to EOHHS by Nursing Facilities. The Contractor shall ensure the SC-1 form is completed and submitted to EOHHS in a form, format, and timeframe specified by EOHHS when an Enrollee enters or leaves a facility and shall include requirements for timely submission of the SC-1 in its contracts with Nursing Facilities.

2.5.2.6.2. Assessment Tool and Process for Enrollees Residing in a Nursing Facility

2.5.2.6.2.1. When an Enrollee is admitted into a Nursing Facility, including Enrollees who are residing in a Nursing Facility at the time of Enrollment, Contractor shall ensure that the facility shall complete an MDS 3.0.

2.5.2.6.2.2. The Contractor shall ensure that the facility completes and submits the MDS 3.0 to EOHHS within fourteen (14) days of admission, and at least annually thereafter. The Contractor shall work with the Facility as needed to ensure timely submission.

2.5.2.6.2.3. The MDS 3.0 shall be conducted or coordinated by a Registered Nurse with the appropriate participation of health professionals.

2.5.2.6.2.4. The MDS 3.0 assessment shall be conducted in person with the Enrollee, include direct observation, and include communication with the Enrollee and direct care staff on all shifts.

2.5.2.7. EOHHS may, at EOHHS's discretion, delegate responsibility for performing assessments for assignment to Rating Categories described in this **Section 2.5.2** to a third party. In the event EOHHS delegates such responsibility to a third party, the Contractor shall collaborate with such entity as directed by EOHHS. EOHHS shall provide written notice to the Contractor no less than ninety (90) days prior to the effective date of any such change.

2.5.3. Care Plan

2.5.3.1. General

2.5.3.1.1. The Contractor shall develop an Individualized Care Plan (ICP) with each Enrollee.

2.5.3.1.2. The ICP shall:

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

2.5.3.1.2.2. Be developed by the PCP or ICT under the direction of the Enrollee (and/or the Enrollee's representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. 422.112(a)(6)(iii) and updated periodically to reflect changing needs identified in ongoing Assessments.

2.5.3.1.2.3. For Enrollees who require LTSS, be developed by a person or persons trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR 441.301(c)(1) and (2).

2.5.3.1.2.4. For Enrollees requiring LTSS, be developed in accordance with the requirements set forth in Appendix D of the Frail Elder Waiver (found at **Appendix S** of this Contract), entitled Participant Centered Service Planning and Delivery. In all instances the Enrollee shall be at the center of the care planning process.

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

2.5.3.1.2.5.1. Their health status, including functional limitations;

2.5.3.1.2.5.2. How family members, caregivers and social supports can be involved in the care planning as the Enrollee chooses;

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

2.5.3.1.2.5.4. Opportunities for educational and vocational activities;

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

2.5.3.1.2.5.6. Their right to choose (i) Covered Services for which they are eligible and (ii) Network Providers to provide such services; and

2.5.3.1.2.5.7. The Enrollee's right to be free from abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation.

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

2.5.3.1.2.6.1. Include, but is not limited to:

2.5.3.1.2.6.1.1. A summary of the Enrollee's health history;

2.5.3.1.2.6.1.2. A prioritized list of concerns, goals, and strengths;

2.5.3.1.2.6.1.3. The plan for addressing concerns or goals;

2.5.3.1.2.6.1.4. A list of all recommended goals (including those that the Enrollee is not ready to address);

2.5.3.1.2.6.1.5. The person(s) responsible for specific interventions;

2.5.3.1.2.6.1.6. The due date for each interventions;

2.5.3.1.2.6.1.7. A list of authorized services and the Enrollee's understanding of available services;

2.5.3.1.2.6.1.8. Identification of, and a plan to address, the member's medical, behavioral health, functional, cognitive and Social Determinant of Health needs**;**

2.5.3.1.2.6.1.9. Contact information for the member's primary caregiver; and

2.5.3.1.2.6.1.10. Identification of the member's Health Care Proxy (or documentation of a conversation to help the member identify a health care proxy)

2.5.3.1.3. MassHealth reserves the right to audit and review Enrollee care plans.

2.5.3.2. Member Approval/Consent

2.5.3.2.1. The Contractor Shall:

2.5.3.2.1.1. Inform an Enrollee of their right to approve the ICP;

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

2.5.3.2.1.3. Obtain Member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is developed via telephone or videoconference, if the audio is recorded, the Contractor shall obtain the Member's consent for the audio recording. The Contractor shall document instances when Members or their representatives refuse to sign the ICP, including a clear explanation of the reason for the Member's refusal;

2.5.3.2.1.4. Provide the Enrollee with access to their ICP;

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

2.5.3.2.1.6. Inform an Enrollee how to submit a Grievance or an Appeal; and

2.5.3.2.1.7. Inform an Enrollee how to contact the Ombudsman.

2.5.3.3. Service Requests

2.5.3.3.1. The Contractor shall:

2.5.3.3.1.1. Accept at any time from an Enrollee a Service Request or other request for a modification of the ICP.

2.5.3.3.1.2. Document all Service Requests and other requests for a modification of the ICP in the Enrollee's Centralized Enrollee Record.

2.5.3.3.1.3. Issue a timely service authorization decision (consistent with **Section 2.10.9**).

2.5.3.3.1.4. Provide proper notice to the Enrollee of the service authorization decision (consistent with **Section 2.10.9.8**), including Appeal rights.

2.5.3.3.1.5. Educate Enrollees about the process and timetable for Service Requests, including but not limited to how long the Plan may take to make a service authorization decision (consistent with **Section 2.10.9**):

2.5.3.3.1.5.1. During onboarding; and

2.5.3.3.1.5.2. Before the annual review of the ICP.

2.5.3.3.1.6. Document the above in the Enrollee's Centralized Enrollee Record.

2.5.3.4. Flexible Benefits

2.5.3.4.1. The ICP may identify Flexible Benefits that may promote independent living or recovery, positively impact outcomes, or address access or other barriers to achieving goals in the ICP.

2.5.3.4.2. Flexible Benefits may be identified and requested in the ICP by the Enrollee, a Provider, or any Member of the Enrollee's ICT as part of Person-Centered Planning. Consistent with **Section 2.10.11**, the Contractor is encouraged to authorize Service Requests for Flexible Benefits in the ICP that add value, including by promoting independent living or recovery, positively impacting outcomes, or addressing barriers to achieving goals in the Enrollee's care plan.

2.5.3.5. Care Plan Linkage to Prior Authorization/Utilization Management

2.5.3.5.1. Service authorization requests may be identified and requested in the ICP by the Enrollee, a Provider, or any Member of the Enrollee's ICT as part of Person-Centered Planning.

2.5.3.5.2. The Contractor shall have policies and procedures in place to ensure that the individuals making an authorization decision notify the Enrollee's GSSC or other coordinator when a modification or denial are considered to confirm all applicable information is reflected in their review.

2.5.3.5.2.1. The GSSC or other coordinator shall ensure all necessary supporting information is provided to the authorizing reviewer, including the Enrollee's ICP, and any additional information from Providers or the Enrollee.

2.5.3.5.2.2. The authorizing reviewer shall review and consider all supporting information, Medical Necessity as defined in this Contract to consider the cumulative effect of Medicare and Medicaid benefits, and value and outcomes as required in **Section 2.10.11**, prior to modifying or denying any service request identified on the ICP.

2.6. Care Coordination and Care Model

2.6.1. Care Coordination/Care Management

2.6.1.1. General

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

2.6.1.1.1.1. Through a GSSC provided through an Aging Service Access Point (ASAP) pursuant to a Material Subcontract, for LTSS; and/or

2.6.1.1.1.2. Through a RN employed by or contracted with the SCO Plan; and

2.6.1.1.1.3. In addition to Enrollees required to have a GSSC assigned, the Contractor may elect to provide care coordination through a GSSC or SCO RN to other SCO Enrollees.

2.6.1.1.2. The Contractor shall provide Enrollees with information on how to contact their coordinator(s). The Contractor shall ensure that communication with each Enrollee's designated coordinator(s) is in accordance with the Enrollee's communication preferences, including through mail, telephone, text, and other electronic means, and including

any interpreter services and other technology to ensure effective communication for the Enrollee.

2.6.1.2. In-Person Care Coordination/Care Management Engagement

2.6.1.2.1. Enrollees shall be engaged by their GSSC and/or SCO RN in-person and in the Enrollee's home. In person visits shall be conducted concurrently with the comprehensive assessment at the frequency as described in **Section 2.5.1.1**.

2.6.1.2.2. Subject to advance approval by EOHHS, the contractor may have policies and procedures to use modalities other than in-person engagement (e.g., virtually with audio and video, or other alternatives approved by EOHHS) for Care Coordination/Care Management engagement in certain cases, based on a particular Enrollee's need and current status.

2.6.1.3. The Contractor shall provide and perform both Administrative and Clinical activities of Care Coordination and Care Management as required for each Enrollee, and as described in this **Section 2.6.1**.

2.6.1.4. Administrative Requirements

2.6.1.4.1. The Contractor shall assign GSSCs and other care coordination staff that are appropriately trained, licensed, and credentialed to perform the required administrative activities described in this **Section 2.6**.

2.6.1.4.2. The Contractor shall ensure the following administrative activities are completed as required for each Enrollee:

2.6.1.4.2.1. Maintain open lines of communication with Enrollees, interact with Enrollees as needed based on Enrollee preferences and care recommendations.

2.6.1.4.2.2. Ensure Enrollees have an ICT composed of all people key to managing their care, communicate with and convene the ICT as needed, and encourage Enrollees to identify ICT Members.

2.6.1.4.2.3. Ensure Enrollees have a current ICP on record.

2.6.1.4.2.4. Maintain Enrollee records to ensure that health plan services (medical, BH, LTSS, social) are recorded and that requests for services are appropriately documented, submitted, tracked and adjudicated.

2.6.1.4.2.5. Ensuring that appropriate mechanisms are in place to receive Enrollee input and Grievances, and secure communication among relevant parties.

2.6.1.4.2.6. Ensure Enrollees can get to appointments and make community connections.

2.6.1.4.2.7. Act as first and primary point of contact for Enrollees, including by assisting Enrollees with navigating health plan processes and interactions, help Enrollees get answers to questions and manage challenges in getting services.

2.6.1.4.2.8. Ensure ADA compliance of services provided.

2.6.1.4.2.9. Educate Enrollees on the SCO benefits/services options.

2.6.1.4.2.10. Help Enrollees find care in their preferred language, arrange for interpreter services as needed.

2.6.1.4.2.11. Facilitate communication and information exchange for the services the Enrollee receives from community and social support providers.

2.6.1.4.2.12. Help Enrollees identify and engage with community-based resources that support social engagement, recovery, Social Determinants of Health (including addressing homelessness, food insecurity and other factors), wellness, and independent living.

2.6.1.5. Clinical Requirements

2.6.1.5.1. The Contractor shall assign GSSCs and other care coordination staff that are appropriately trained, licensed, and credentialed to perform the required clinical activities described in this Section.

2.6.1.5.2. The following clinical activities shall be completed as required for each Enrollee:

2.6.1.5.2.1. Arrange and ensure that appropriate assessments, evaluations, and in-home resources are available;

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

2.6.1.5.2.3. Conduct Comprehensive Assessments appropriately and as required in the Contract, adjust ICP as necessary and with Enrollee’s knowledge and consent, and communicate

the information to the Enrollee's Providers in a timely manner;

2.6.1.5.2.4. Document and access Enrollees' care plans, healthcare needs, and goals;

2.6.1.5.2.5. Review and reconcile medication;

2.6.1.5.2.6. Adjust medication by protocol;

2.6.1.5.2.7. Be available and accessible to Enrollees to help answer questions and get needs met, provide interventions, as necessary;

2.6.1.5.2.8. Enhance self-management training and support for complex clinical conditions, including coaching for family members if appropriate;

2.6.1.5.2.9. Access health plan escalation processes if there are concerns about Enrollee needs and/or preferences being appropriately addressed;

2.6.1.5.2.10. Support safe transitions in care for Enrollees moving between settings;

2.6.1.5.2.11. Ensure post-hospitalization services are discussed with Enrollees and put into place (for both medical and BH conditions);

2.6.1.5.2.12. Assist Enrollees in connecting with recovery supports necessary to prevent hospitalization or re-hospitalization;

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

2.6.1.5.2.14. Follow-up within twenty-four hours of an Enrollee's admission to an acute hospital, and coordination with the Enrollee and hospital staff to facilitate hospital discharges;

2.6.1.5.2.15. Provide care coordination to Enrollees residing in a SNF or nursing facility that has a positive PASRR level II screening;

2.6.1.5.2.16. Report concerns about abuse or neglect to the appropriate agency (i.e., Executive Office of Aging & Independence (AGE) for adults ages 60 and over); and

2.6.1.5.2.17. Frequent Enrollee contact, as appropriate.

2.6.1.6. Geriatric Support Services Coordinator (GSSC)

2.6.1.6.1. The Contractor shall 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. A GSSC must meet the standards established by the AGE in designating ASAPs as qualified to serve as GSSCs. If more than one ASAP is operating in the Contractor's Service Area, the Contractor may:

2.6.1.6.2. Contract with all the ASAPs; or

2.6.1.6.3. Contract with a lead ASAP to coordinate all the GSSCs.

2.6.1.6.4. The GSSC is responsible for:

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

2.6.1.6.4.1.1. Arranging, coordinating and authorizing the provision of LTSS and community long-term care and social support services, based on the Enrollee's needs assessment and ICP and with the agreement of other care team Members designated by the Contractor;

2.6.1.6.4.1.2. Coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing;

2.6.1.6.4.1.3. 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 interdisciplinary care team;

2.6.1.6.4.1.4. Tracking Enrollee transfer from one setting to another; and

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

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

2.6.1.6.5. If only one ASAP is 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 shall follow the procedure described below:

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

2.6.1.6.5.2. 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

2.6.1.6.6. If the Contractor has identified any of the deficiencies described above, is unable to execute a contract with an ASAP, or determines that it shall terminate a GSSC contract with an ASAP, and that is the only ASAP that operates in the Contractor's Service Area, the Contractor shall 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 shall develop a corrective action plan for the Contractor that ensures continuation of GSSC services and specifies the actions the Contractor shall take.

2.6.1.6.7. 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.

2.6.1.6.8. 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 shall collaborate with EOHHS and AGE 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 shall terminate a contract with an ASAP, and that is the only ASAP operating in its Service Area, the Contractor shall follow the procedure in **Section 2.6.1.6.5**. The Contractor shall cooperate with EOHHS and the AGE to ensure any claims submitted by the ASAPs are accepted and processed through a standardized system. The Contractor shall ensure GSSC services are not duplicated by other care management functions delivered by the Contractor, Providers or Material Subcontractors and that care management is only counted once for each Member in the Medicaid MLR calculation, as that term is defined in **Section 4.5.5**.

2.6.1.6.9. Nothing in this **Section 2.6.1.6** precludes the Contractor from entering into a subcontracting relationship with any ASAP for functions beyond those required by M.G.L. c. 118E § 9D, any such

subcontracting relationship shall meet all requirements and standards for any Material Subcontractor and shall comply with all provider qualifications and provider monitoring standards in **Sections 2.8** and **2.9**, such subcontracted functions may include:

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

2.6.1.6.9.2. Performing assessments; and

2.6.1.6.9.3. Conducting risk-assessment and care planning activities regarding non-medical service needs of Enrollees who do not require Complex Care.

2.6.1.7. Nursing Facility Care Coordination

2.6.1.7.1. For Enrollees receiving nursing facility services, the Contractor shall:

2.6.1.7.1.1. Conduct an in-person comprehensive assessment;

2.6.1.7.1.2. Monitor and modify as necessary the Enrollee's ICP to include all specialized services, behavioral health, and rehabilitative services identified in the PASRR evaluation, as well as other needs identified through the comprehensive assessment;

2.6.1.7.1.3. Make any necessary referrals and coordinate those referrals for the provision of the services identified in the ICP; and

2.6.1.7.1.4. Offer an in-person visit monthly and complete an in-person visit with Enrollees receiving nursing services quarterly (and make phone calls/telehealth visits as appropriate between in-person visits).

2.6.2. Interdisciplinary Care Team

2.6.2.1. The Contractor shall arrange for each Enrollee, in a manner that respects the needs and preferences of the Enrollee, the formation and operation of an ICT. The Contractor shall ensure that each Enrollee's care is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to their licensure and relationship with the Enrollee. The Enrollee shall be encouraged to identify individuals they would like to participate on the ICT.

2.6.2.2. The ICT shall consist of at least the following staff:

2.6.2.2.1. The Enrollee's PCP; and

2.6.2.2.2. A Geriatric Support Services Coordinator (GSSC), if indicated, as specified in **Section 2.6.1.4** or a RN provided by the SCO.

2.6.2.2.3. As appropriate and at the discretion of the Enrollee, the ICT may also include additional participants.

2.6.2.3. The Contractor shall ensure that the PCP or the ICT integrates and coordinates services including, but not limited to:

2.6.2.3.1. An ICP, as described in **Section 2.5.3** of this Contract,

2.6.2.3.2. Written protocols for generating or receiving referrals and for recording and tracking the results of referrals,

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

2.6.2.3.4. Written protocols for sharing clinical and ICP information, including management of medications,

2.6.2.3.5. Written protocols for determining conditions and circumstances under which specialty services shall be provided appropriately and without undue delay to Enrollees who do not otherwise require Complex Care,

2.6.2.3.6. 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,

2.6.2.3.7. Coordinating the services the Contractor furnishes to the Enrollee between settings of care, including appropriate discharge planning for short- and long-term hospital and nursing facility stay, and

2.6.2.3.8. Coordinating services provided by the Contractor with the services the Enrollee receives from community and social support providers.

2.6.2.4. 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 their designee on the ICT.

2.6.2.5. An ICT documented conversation is required if the Enrollee's ICP goals are not being met, furthermore the frequency of ICT meetings should be increased accordingly.

2.6.3. Care Transition and Discharge Planning

2.6.3.1. General

2.6.3.1.1. For purposes of this Section, transitions of care shall include transitions across facility and community settings, typically referred to as discharges and admissions, including:

2.6.3.1.1.1. Inpatient discharge or transition, including but not limited to discharge from an acute inpatient hospital, nursing facility, chronic disease and rehabilitation hospital, psychiatric inpatient hospital, or substance use disorder hospital, collectively referred to as “inpatient discharge;”

2.6.3.1.1.2. Discharge from a twenty-four (24) hour diversionary setting, Emergency Department (ED), or any other change in treatment setting;

2.6.3.1.1.3. Admissions, including an Enrollee entering an inpatient setting or a different residential treatment setting, a twenty-four (24) -hour diversionary service setting, an ED, and other setting changes in which an Enrollee receives ongoing support services or treatment.

2.6.3.1.2. Where appropriate, the Contractor shall encourage its providers to adopt of evidence-based health at home models;

2.6.3.1.3. Prior to a transition in care, the Contractor shall ensure the ICT, including the designated care coordinator assists in the development of an appropriate discharge or transition plan, including on-site presence in acute settings if appropriate;

2.6.3.1.4. For Enrollees who require new or changing LTSS supports, the Contractor shall ensure that the Enrollee’s GSSC is present at or otherwise participates in discharge planning meetings;

2.6.3.1.5. For Enrollees who are moving from a qualifying long-stay in a nursing facility, the Contractor shall provide necessary Transitional Assistance Services administered through the Frail Elder Waiver as described in **Appendix S**.

2.6.3.1.6. The Contractor shall develop, implement, and maintain written protocols and operational capabilities to ensure an appropriate exchange of information about the Enrollee to facilitate effective transitions for Enrollees as necessary. Such information shall include:

2.6.3.1.6.1. Primary diagnoses and major health problems;

2.6.3.1.6.2. A care plan that includes Enrollee goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable);

2.6.3.1.6.3. An Enrollee's Advance Directives, and power of attorney;

2.6.3.1.6.4. Emergency plan and contact number and person;

2.6.3.1.6.5. Reconciled medication list;

2.6.3.1.6.6. Identification of, and contact information for, transferring clinician/institution;

2.6.3.1.6.7. An Enrollee's cognitive and Functional Status;

2.6.3.1.6.8. Follow-up appointment schedule with contact information;

2.6.3.1.6.9. Formal and informal caregiver status and contact information; and

2.6.3.1.6.10. Designated community-based care provider, long-term services, and social services as appropriate.

2.6.3.1.7. The Contractor shall develop, implement, and maintain protocols for facilitating timely and effective Care Transitions between settings, including with all Network Hospitals and Nursing Facilities. Such protocols shall include elements such as but not limited to the following:

2.6.3.1.7.1. Event notification protocols that ensure key providers and individuals involved in an Enrollee's care are notified of admission, transfer, discharge, and other important care events, for example, accessing or receiving event notifications from an EOHHS-Certified ENS Vendor participating in the Statewide ENS Framework. Such key providers shall include but not be limited to an Enrollee's PCP, Behavioral Health provider if any, LTSS provider (e.g., Personal Care Attendant) if any, and GSSC or other designated care coordinator;

2.6.3.1.7.2. Discharge Planning activities occurring at the time of admission;

2.6.3.1.7.3. Prioritizing return to an appropriate home or community-based setting rather than a facility setting whenever possible, including proactive planning to identify and mitigate barriers to effectively supporting an Enrollee to return to and remain in their home, and make best efforts to ensure a smooth transition to the next service or to the community;

2.6.3.1.7.4. Policies and procedures to ensure inclusion of Enrollees and Enrollees' family members/guardians and caregivers, as applicable, in Discharge Planning and follow-up, and to ensure appropriate education of Enrollees, family members, guardians, and caregivers on post-discharge care instructions;

2.6.3.1.7.5. Inclusion of the Enrollee's Behavioral Health provider, if any, and LTSS providers (e.g., Personal Care Attendant) if any in Discharge Planning and follow-up;

2.6.3.1.7.6. Identification of the Enrollee's State agency affiliation, release of information, and coordination with any State agency representative assigned to the Enrollee;

2.6.3.1.7.7. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;

2.6.3.1.7.8. Include protocols for documenting all efforts related to Care Transitions and Discharge Planning in the Enrollee's medical record, including the Enrollee's active participation, goals, and preferences;

2.6.3.1.7.9. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards;

2.6.3.1.7.10. Referral to and care coordination with post-acute and outpatient providers as needed, including community-based support services providers;

2.6.3.1.7.11. Telephonic or other follow-up with Enrollees within forty-eight (48) hours of an inpatient encounter;

2.6.3.1.7.12. Culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;

2.6.3.1.7.13. Patient-centered self-management support and relevant information specific to the Enrollee's condition and any ongoing risks; and

2.6.3.1.7.14. Home visits post-discharge as required by the Enrollee.

2.6.3.2. Follow-up Requirements Post-Discharge

2.6.3.2.1. Within seven (7) calendar days following an Enrollee's emergency department (ED) discharge, seven (7) calendar days following an Enrollee's inpatient discharge, discharge from twenty-four (24) hour

diversionary setting, or transition to a community setting, the Contractor shall ensure the care coordinator follows up with the Enrollee face-to-face or via telehealth (e.g., telephone or videoconference, or as further specified by EOHHS), and at a minimum:

2.6.3.2.1.1. Discusses with the Enrollee, and with the Enrollee's consent, updates the Enrollee's Care Plan, and

2.6.3.2.1.2. Coordinates clinical services, in-home or community-based services, and other supports for the Enrollee, as needed.

2.6.3.2.2. Following an Enrollee's emergency department (ED) discharge, inpatient discharge, discharge from twenty-four (24) hour diversionary setting, or transition to a community setting, the Contractor shall ensure that an appropriately licensed and credentialed individual, such as a registered nurse (RN) or a licensed practical nurse (LPN) under the oversight and supervision of an RN:

2.6.3.2.2.1. Reviews the updated Care Plan, if applicable;

2.6.3.2.2.2. Conducts a formal Medication Reconciliation that includes a comprehensive Medication Review and provides Medication Management as needed, including ensuring that Enrollees who require medication monitoring shall have access to such services within seven (7) business days of discharge from a behavioral health inpatient setting; and

2.6.3.2.2.3. Discusses with the Enrollee and the Enrollee's ICT plans to better support the Enrollee to prevent future admissions or re-admissions, as appropriate.

2.6.3.2.2.4. The Contractor shall ensure the designated care coordinator monitors and updates ICT Members on the Enrollee's status following transitions in care; and

2.6.3.2.2.5. The Contractor shall ensure that the GSSC or other designated care coordinator assists Enrollees in accessing supports to which they are referred following a transition of care.

2.6.3.2.2.6. Assurance that inpatient and twenty-four (24) hour diversionary Behavioral Health Providers provide a discharge plan following any behavioral health admission to ICT Members,

2.6.3.3. Discharge Planning for Enrollees Experiencing or At Risk of Homelessness

2.6.3.3.1. The Contractor shall, as further directed by EOHHS, including but not limited to in Managed Care Entity Bulletins, implement policies and procedures that ensure timely, appropriate, and comprehensive Discharge Planning for Enrollees experiencing homelessness or Enrollees at risk of homelessness. Such policies and procedures shall be consistent with federal and state privacy laws and regulations and shall be incorporated into the Contractor's protocols for Care Transitions with all Network Hospitals.

2.6.3.3.2. In addition to the requirements above in **Section 2.6.3.2**, ensure that Discharge Planning activities include the following as further specified by EOHHS:

2.6.3.3.2.1. The hospital shall contact the Contractor at the time of admission in order to collaborate in identifying resources to assist with the Enrollee's housing situation;

2.6.3.3.2.2. At the time of admission, and as part of its general Discharge Planning processes, the hospital shall assess each admitted Enrollee's current housing situation; and

2.6.3.3.2.3. The hospital shall invite and encourage participation in Discharge Planning, as appropriate, by the Enrollee, the Enrollee's family, providers, Community Partner, care coordinators, shelter staff, and any other supports identified by the Enrollee.

2.6.3.3.2.4. For any Enrollee who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), MassAbility, or AGE, the hospital shall invite and encourage designated staff from each such agency to participate in such Enrollee's discharge planning activities.

2.6.3.3.2.5. For any Enrollee that is not a client of DMH, DDS, MassAbility, or AGE, the hospital shall determine whether the Enrollee may be eligible to receive services from some or all of those agencies and offer to assist in submitting an application to DMH, DDS, MassAbility, or AGE as appropriate.

2.6.3.3.2.6. The hospital shall determine whether the Enrollee has any substance use disorder, as further specified by EOHHS. For any such Covered Individual, the Provider must contact the Massachusetts Substance Use Helpline (800) 327-5050, the statewide, public resource for finding substance use treatment, recovery options, and assistance with problem gambling, or successor Helplines as identified by EOHHS.

The Helpline's trained specialists will help the Enrollee understand the available treatment services and their options.

2.6.3.3.3. Ensure that Discharge Planning activities include the following assessment of options for discharge as further specified by EOHHS:

2.6.3.3.3.1. The hospital shall ensure that discharge planning staff are aware of and utilize available community resources to assist with Discharge Planning.

2.6.3.3.3.2. For any Enrollee with skilled care needs, who needs assistance with activities of daily living, or whose behavioral health condition would impact the health and safety of individuals residing in the shelter, the hospital shall make all reasonable efforts to prevent discharges to emergency shelters. For such Enrollees, the hospital shall seek placement in more appropriate settings, such as DMH community-based programs or nursing facilities.

2.6.3.3.3.3. For any Enrollee who was experiencing homelessness prior to admission and is expected to remain in the hospital for fewer than 14 days, the hospital shall contact the appropriate emergency shelter to discuss the Enrollee's housing options following discharge, as further specified by EOHHS.

2.6.3.3.3.4. For any Enrollee for whom discharge to an emergency shelter or specific placement cannot be secured, the hospital shall provide additional supports and track discharges of such Enrollees as further specified by EOHHS.

2.6.3.3.4. For the purposes of this **Section 2.6.3**, Enrollees experiencing homelessness shall be any Enrollee who lacks a fixed, regular, and adequate nighttime residence and who:

2.6.3.3.4.1. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group;

2.6.3.3.4.2. Is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals; or

2.6.3.3.4.3. Is chronically homeless as defined by the US Department of Housing and Urban Development (see also **Section 1.31** of this Contract).

2.6.4. Coordinating Care and Services with Federal, State, and Community Agencies

2.6.4.1. General

2.6.4.1.1. The Contractor shall implement a systematic process for coordinating care and creating linkages between Enrollees and organizations that provide services not covered, including but not limited to:

2.6.4.1.1.1. State agencies, including e.g., the Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and DPH's Bureau of Substance Addiction Services (DPH/BSAS), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), Massachusetts Rehabilitation Commission, and the Executive Office of Aging & Independence (AGE);

2.6.4.1.1.2. Social service agencies;

2.6.4.1.1.3. Community-based mental health and substance use disorder programs;

2.6.4.1.1.4. Consumer, civic, and religious organizations; and

2.6.4.1.1.5. Federal agencies (e.g., the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

2.6.4.2. Requirements

2.6.4.2.1. The systematic process and associated linkages shall provide for:

2.6.4.2.1.1. Sharing information and generating, receiving, and tracking referrals;

2.6.4.2.1.2. Obtaining and recording consent from Enrollees to share individual Enrollee medical information where necessary; and

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

2.6.4.2.1.4. The Contractor shall designate a State Agency Liaison as described in **Section 2.3.1**.

2.6.4.3. Ombudsman

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

2.6.4.3.1.1. Educating Enrollees about the availability of Ombudsman services:

2.6.4.3.1.2. On the Contractor's website;

2.6.4.3.1.3. When Enrollees receive the Member Handbook;

2.6.4.3.1.4. At the time of the Comprehensive assessments; and

2.6.4.3.1.5. When Enrollees, and their family members and representatives, contact SCO plan staff, including CSRs, with a Grievance or Appeal.

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

2.6.4.3.2.1. Providing Ombudsman staff with access to records needed to investigate and resolve Enrollee Grievances (with the Enrollee's consent); and

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

2.6.5. Continuity of Care

2.6.5.1. For all services other than Part D drugs, the Contractor shall develop policies and procedures to ensure continuity of care for all Enrollees into the Contractor's SCO Plan for whichever is the longer of:

2.6.5.1.1. A period of up to ninety (90) days following the Effective Enrollment Date, unless the Comprehensive Assessment and the ICP

are completed (developed and reviewed with the Enrollee, including any changes in providers, services, or medications) sooner and the Enrollee agrees to the shorter time period; or

2.6.5.1.2. Until the Comprehensive Assessment and ICP are complete (developed and reviewed with the Enrollee, including any changes in providers, services, or medications).

2.6.5.2. Continuity of Care policies shall apply any time an individual enrolls into the Contractor's SCO Plan, including for Members enrolling from other SCO plans or MassHealth health plans, or PACE.

2.6.5.3. Any service an Enrollee receives from the Enrollee's prior insurance carrier that the Contractor will not cover after the Enrollee's continuity of care period shall be considered a reduction, modification, or denial of a currently authorized service. The Contractor shall provide advance notice and all Appeal rights, including Continuing Services, required for adverse Integrated Organization Determinations described in **Section 2.13**, and according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568.

2.6.5.4. Such policies and procedures shall be consistent with 42 C.F.R. § 438.62(b)(1) and 42 C.F.R. § 422.112(b) and for the purpose of:

2.6.5.4.1. Minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary services;

2.6.5.4.2. Ensuring that the Enrollee is established with any new service Providers, as indicated by the ICP, so that no gap in ongoing services occurs;

2.6.5.4.3. For an Enrollee that has not transitioned to the Contractor's Network Providers at the conclusion of the 90-day continuity of care period, the Contractor shall make best efforts to provide uninterrupted care beyond the 90-day period and shall establish policies and procedures to this effect. Such policies and procedures shall include, but not be limited to, honoring authorizations from the Enrollee's previous plan until the Contractor issues new authorizations for Medically Necessary services; paying non-network providers for services until such Enrollees have been transitioned to a Network Provider; and other measures as further specified by EOHHS;

2.6.5.4.4. Intaking and honoring prior authorizations at the time of enrollment that have been issued by MassHealth or its designee, by another SCO plan, MassHealth health plan, or PACE Organization, and by Medicare until the ICP is complete and any new or updated authorizations have been issued;

2.6.5.4.5. Preventing gaps and disruptions in LTSS and ongoing support services, such as PCA, routines such as attending a particular day program; and

2.6.5.4.6. Ensuring that such Providers are able to confirm or obtain any authorization, if needed, as well as payment for any such services from the Contractor.

2.6.5.5. In addition to general Continuity of Care policies for all Enrollees, the Contractor shall have specific policies and procedures at a minimum for the Enrollees who, at the time of their Enrollment:

2.6.5.5.1. Have significant health care needs or complex medical conditions;

2.6.5.5.2. Are receiving ongoing services such as dialysis, home health, chemotherapy and /or radiation therapy;

2.6.5.5.3. Are hospitalized, in a nursing facility, or in a residential service setting; or

2.6.5.5.4. Are receiving treatment for behavioral health or substance use disorder treatment; or

2.6.5.5.5. Are receiving ongoing supports for ADLs and/or IADLs;

2.6.5.5.6. Have received prior authorization for SCO Covered Services including but not limited to:

2.6.5.5.6.1. Scheduled and unscheduled inpatient care (medical and Behavioral Health), outpatient procedures, and admission to a nursing facility;

2.6.5.5.6.2. Out-of-area specialty services; or

2.6.5.5.6.3. Durable medical equipment (DME) or prosthetics, orthotics, and supplies, Physical therapy (PT), occupational therapy (OT), or speech therapy (ST);

2.6.5.5.6.4. PCA and other LTSS;

2.6.5.5.6.5. Oral health care and procedures; and

2.6.5.5.6.6. Other medically necessary services.

2.6.5.5.7. Are enrolled in the Frail Elder Waiver including but not limited to:

2.6.5.5.7.1. Enrollment in SCO does not substitute for the requirement included in Appendix B-6-a of the Frail Elder Waiver (**Appendix S**) that a participant must receive at least one

waiver service per month in order to maintain waiver eligibility.

2.6.5.6. The Contractor shall have specific policies and procedures for:

2.6.5.6.1. Identifying and communicating with Enrollees for whom Continuity of Care is required in accordance with this Section, and those Enrollees' providers (including but not limited to Network Providers);

2.6.5.6.2. Facilitating continuity of care so that Enrollees may continue to see their current providers (including but not limited to Network Providers) for Medically Necessary Behavioral Health Covered Services for at least ninety (90) days from the Enrollee's Effective Enrollment Date;

2.6.5.6.3. Ensuring that Enrollees currently receiving inpatient care (medical, Behavioral Health, post-acute or custodial care) from a hospital or nursing facility, including non-Network hospitals and non-network nursing facilities, at the time of their Enrollment may continue to receive such care from such hospital or nursing facility as long as such care is Medically Necessary. The Contractor shall make best efforts to contact such facility to ensure such Continuity of Care; and

2.6.5.6.4. Ensuring Enrollees with upcoming appointments, ongoing treatments or services, prior authorizations, and services previously authorized by another SCO plan, other MassHealth health plan, PACE Organization, Medicare plan, or a commercial carrier may continue to seek and receive such care from providers (including non-Network) with whom they have an existing relationship for such care.

2.6.5.7. The Contractor shall ensure such continuity by providing new authorization or extending existing authorization, if necessary, for the duration of such prior authorizations and prior approvals, without regard to Medical Necessity criteria, for at least the required 90-day period.

2.6.5.8. If the Contractor chooses to modify or terminate a prior authorization and prior approval, then the Contractor shall treat such modification or termination as an Adverse Action and follow the appeal rights policy and procedures, including notification to the Enrollee and the Enrollee's provider in question.

2.6.5.9. The Contractor shall have the ability to:

2.6.5.9.1. Accept and utilize medical records, claims histories, and prior authorizations from an Enrollee's previous SCO plan, other MassHealth health plan, PACE Organization, MassHealth, MassHealth FFS providers, Medicare, or a commercial carrier.

2.6.5.9.2. Accept the transfer of all administrative documentation, as directed by EOHHS.

2.6.5.10. For Enrollees affiliated with other state agencies, the Contractor shall ensure coordination and consultation with such agencies as described in **Section 2.6.4, 2.7 and 5.3.8**;

2.6.5.11. As directed by EOHHS, the Contractor shall participate in any other activities determined necessary by EOHHS to ensure the continuity of care for Enrollees;

2.6.5.12. Continuity of PCA Services for Enrollees During Disenrollment:

2.6.5.12.1. Upon the disenrollment of an Enrollee who receives PCA services, in addition to any other continuity of care requirements imposed by law, regulation, or this Contract, the Contractor shall comply with EOHHS-prescribed continuity of PCA service procedures.

2.6.6. Enrollees with Special Health Care Needs

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

2.6.6.2. In accordance with 42 CFR 438.208(c), Enrollees with Special Health Care Needs have access to care coordination as part of the SCO Plan's Care Model, including having assessments as described in **Section 2.5.1**, engagement in person-centered care planning as described in **Section 2.5.3**, care coordination as described in **Section 2.6.1**, and direct access to specialists as described in Section **2.10.6.** Assessment of the quality and appropriateness of care furnished to such individuals occurs through the Contractor’s Quality Improvement Activities described in **Section 2.14.3**.

2.6.7. FIDE SNP Model of Care

2.6.7.1. In accordance with Section 1859(f)(7) of the Social Security Act, the Contractor’s Model of Care as approved by the National Committee for Quality Assurance (NCQA) for its SCO Plan shall comply with all EOHHS requirements described in this Section. These EOHHS requirements are in addition to all existing Medicare Advantage Special Needs Plan Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual.

2.6.7.2. The Contractor's model of care shall support EOHHS's goals to ensure all Enrollees have access to equitable, high-quality care and to provide Care Coordination and Care Management services that are responsive to Enrollee needs and risks, which may change over time. In addition, the Contractor's model of care must prioritize the goal of Enrollees maintaining their independence in the community and/or the least restrictive clinically appropriate setting through continuity of care and seamless transitions for Enrollees across the full continuum of physical health, behavioral health, pharmacy, LTSS, oral health and social service needs.

2.6.7.3. The Contractor's Model of Care shall include the following required elements:

2.6.7.3.1. A description of how the training for Geriatric Support Services Coordinators (GSSCs) incorporates the State's Home and Community-based Services (HCBS) and Long-term Services and Supports (LTSS) requirements.

2.6.7.3.2. Standards used to document that the ICP addresses State required managed LTSS care plan elements.

2.6.7.3.3. Integrate physical health, behavioral health, pharmacy, oral health, LTSS, HCBS, and social service needs into the Contractor's approach to the provision of services.

2.6.7.3.4. The Contractor's process for authorizing and approving Flexible Benefits identified and requested through the care planning process described in **Section 2.5.3** and **2.7.1** of the Contract.

2.6.7.3.5. Specify how the Contractor confirms LTSS services restart at the time of discharge from a twenty-four (24) hour care setting.

2.6.7.3.6. That information about beneficiary's Medicare and Medicaid services, including MLTSS, is communicated from the GSSC or the Care Manager to the primary care provider or team, and that the care coordinator models are tailored to the differences in settings and needs between institutional and community Members.

2.6.7.3.7. Explain how the plan tailors or modifies its interpretation of clinical practice guidelines to ensure they are appropriate and account for differences in frailty levels, including those Members receiving HCBS and LTSS.

2.6.7.3.8. Describe measures the Contractor shall use and interpret to account for differences in care delivery models and settings of care among Members, including for the frail elderly (and particularly those receiving HCBS and LTSS).

2.6.7.3.9. Additional elements as required by EOHHS, including policy updates promulgated through regulations and bulletins issued by EOHHS.

2.6.7.4. The Contractor shall submit to EOHHS the Model of Care (MOC) required under Social Security Act Section 1859(f)(7), including care management roles and responsibilities of each Member of the ICT. The Contractor shall submit to EOHHS the MOC at the same time as the Contractor is submitting the MOC to CMS and NCQA for review. In addition, the Contractor shall submit the MOC to EOHHS annually, notifying EOHHS of any changes made to the MOC. Finally, the Contractor shall submit the MOC score, and all summary-level performance reporting exchanged with CMS or NCQA, within five (5) business days of exchange with CMS or NCQA.

2.6.8. Critical Incidents

2.6.8.1. The Contractor shall participate in efforts to prevent and minimize the potential for incidents and/or accidents, and to minimize the impact to MassHealth members from any incidents and/or accidents that do occur; and

2.6.8.2. The Contractor shall notify EOHHS of Critical Incidents as described in Managed Care Entity Bulletin 111 (or any successor MCE Bulletins), and as described in **Appendix A**.

2.7. Covered Services and Care Delivery

2.7.1. General

2.7.1.1. The Contractor shall provide a benefit package that includes the comprehensive set of Covered Services referenced in **Section 2.7.2** and listed in **Appendix C**. The Contractor shall authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. Covered Services shall be available to all Enrollees, as authorized by the Contractor. Covered Services shall be managed and coordinated by the Contractor through the Interdisciplinary Care Team (ICT) (see **Section 2.6.2**).

2.7.1.2. The Contractor shall provide the full range of Covered Services. If Medicare or MassHealth provides more expansive services for a particular condition, type of illness, or diagnosis, the Contractor shall provide the most expansive set of services required by either program, including the cumulative effect as provided by the combination of Medicare and MassHealth. The Contractor may not limit or deny services to Enrollees based on either Medicare or MassHealth providing a more limited amount, duration, type, frequency, or scope services than the other program.

2.7.1.3. The Contractor shall provide all Covered Services in an amount, duration, type, frequency, and scope that is no less than the amount, duration, type, frequency, and scope for the same services provided under MassHealth fee-for-service.

2.7.1.4. The provision of Covered Services shall be in accordance with medical necessity and without any predetermined limits, unless specifically stated (see **Section 2.7.2**), and shall be provided as set forth in 42 C.F.R. Parts 440, 434, and 438.

2.7.1.5. The Contractor shall ensure that all Covered Services are sufficient in amount, duration, and scope, as well as type and frequency, to reasonably achieve the purpose for which the services are furnished.

2.7.1.6. As described in **Appendix C**, Covered Services include:

2.7.1.6.1. All services provided under Medicare Part A, Part B, and Part D, in that the Contractor's Medicare Contract provides primary coverage of Medicare services, and this Medicaid Contract provides secondary coverage for Medicare primary services, which includes Medicaid payment of Medicare cost-sharing and eligible individuals' Medicaid benefits, which may exceed or complement Medicare primary benefits in amount, duration, or scope, as well as type and frequency;

2.7.1.6.2. All Medicaid services listed and defined in **Appendix C**; and

2.7.1.6.3. Pharmacy products that are covered by MassHealth, which are not covered under Medicare Part D, including over-the-counter drugs and prescription vitamins and minerals specified in the MassHealth Drug List. Contractors are encouraged to offer a broader drug formulary than minimum requirements.

2.7.1.7. Additions to Medicaid required services enacted through legislative or judicial change, including midyear updates, will not require a Contract revision or agreement by all parties prior to the Contractor offering providing or arranging for the service to Enrollees.

2.7.1.8. Medicaid payment of Medicare cost-sharing.

2.7.1.9. In addition to the Covered Services described above, the Contractor may provide Flexible Benefits, as specified in the Enrollee's Individualized Care Plan and as appropriate to address the Enrollee's needs.

2.7.1.10. FIDE SNP Coverage

2.7.1.10.1. Medically Necessary nursing facility services shall be no more restrictive than the State plan nursing facility benefit, including stays in excess of 180 days as Medically Necessary.

2.7.1.10.2. The Contractor shall provide SNF care as part of its Medicare covered benefits without requiring a prior qualifying hospital stay, as permitted in 42 CFR 422.101(c)(2).

2.7.1.10.3. EOHHS may require the Contractor to cover certain items or services as Medicare Supplemental Benefits. The Contractor shall:

2.7.1.10.3.1. Collaborate with EOHHS in the planning and development of Supplemental Benefit offerings for the following Contract Year.

2.7.1.10.3.2. Coordinate Supplemental Benefits and Medicaid Benefits, including ensuring that any services covered as Supplemental Benefits that overlap with Medicaid Benefits shall first be adjudicated as Supplemental Benefits and reflected as such in the Contractor's encounter data and financial reporting submissions.

2.7.1.10.3.3. Annually provide, in a form and format determined by EOHHS, an analysis of the overlap and interaction of any Supplemental Benefits and comparable or related Medicaid Benefits, including those benefits covered under the Frail Elder Waiver.

2.7.1.10.3.4. Prioritize using its Medicare rebate amount to first fully cover dental services no less restrictive than those outlined in 130 CMR 420.000 as a Medicare Supplemental Benefit, and second to cover consumer over-the-counter costs as a Medicare Supplemental Benefit.

2.7.1.10.3.5. With the exception of funding MassHealth Dental services with Medicare rebate dollars and reporting related encounters to EOHHS as Medicare encounters, all requirements of this Contract shall apply, including all scope, definition, process, network, accessibility, and other requirements for Covered MassHealth Dental services as described in **Appendix C, Exhibit 1**.

2.7.1.10.3.6. External Appeals for Dental Services paid for with Medicare rebate dollars as Medicare Supplemental Benefits shall be auto-forwarded to the Medicare IRE as described in **Section 2.13.5.1**, and may be simultaneously appealed to the MassHealth BOH as described in **Section 2.13.5.2**; the Enrollee shall be provided **Continuing Services** for

previously authorized or provided services as described in **Section 2.13.7**.

2.7.1.10.3.7. In the event that the Contractor does not anticipate having a sufficient Medicare rebate amount to fully cover such dental services as a Medicare Supplemental Benefit after exhausting the full available rebate amount, the Contractor shall notify EOHHS immediately.

2.7.1.11. For Enrollees enrolled in the Frail Elder Waiver, the Contractor shall be able to report the amount, duration, type, frequency, and scope of waiver services authorized and delivered as described in Appendix A of the Frail Elder Waiver (**Appendix S**).

2.7.2. Medical Necessity

2.7.2.1. The Contractor shall:

2.7.2.1.1. Authorize, arrange, coordinate, and provide timely to Enrollees all Medically Necessary Covered Services as described in this **Section 2.7.2**, in accordance with the requirements of this Contract, including **Section 1.103**; and

2.7.2.1.2. The Contractor shall develop and implement policies and procedures to ensure that all Medically Necessary Services are provided to Enrollees based on their individual health care and functional needs and consistent with **Appendix C**. Such policies and procedures, including any updates to existing policies and procedures, shall be submitted to EOHHS for review upon request.

2.7.2.2. The Contractor shall not:

2.7.2.2.1. Arbitrarily deny or reduce the amount, duration, or scope, or type or frequency, of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee; or

2.7.2.2.2. Deny authorization for a Covered Service that the Enrollee or the provider demonstrates is Medically Necessary.

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

2.7.2.3.1. Developed with input from practicing physicians in the Contractor's Service Area.

2.7.2.3.2. Developed in accordance with standards adopted by national accreditation organizations.

2.7.2.3.3. Updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice.

2.7.2.3.4. Evidence based, if practicable; and

2.7.2.3.5. Applied in a manner that considers the individual health care and functional needs of the Enrollee.

2.7.2.4. Medicare and MassHealth coverage and benefits, including how such benefits would be provided to an Eligible Individual with MassHealth Standard in MassHealth FFS, including MassHealth Dental services purchased through a TPA, shall be the minimum standard for coverage and benefits the Contractor shall provide to its Enrollees. Limits in either Medicare or MassHealth shall not be construed to limit the amount, duration, or scope, or type or frequency of benefits the Contractor shall provide to Enrollees in accordance with this Contract, unless otherwise specified herein.

2.7.2.5. The Contractor's Medical Necessity criteria shall not limit a Covered Service to either the Medicare or the MassHealth criteria when the combination or cumulative effect of such Medicare and MassHealth coverage would result in an increased minimum amount, duration, or scope, or type or frequency.

2.7.2.6. The Contractor's Medical Necessity guidelines, program specifications, and service components for all Covered Services shall, at a minimum, be submitted to EOHHS for approval no later than sixty (60) days prior to any change, except as specified by EOHHS.

2.7.3. Cost-Sharing for Covered Services

2.7.3.1. The Contractor shall not charge Medicaid cost-sharing to SCO Enrollees;

2.7.3.2. The Contractor shall not charge Medicare Part C premiums for its SCO Plan;

2.7.3.3. The Contractor shall be responsible for paying the cost of Medicare Part A and Part B cost-sharing for its SCO Plan;

2.7.3.4. Enrollee Contribution to Care Amounts for Enrollees residing in a nursing facility as described in **Section 4.2.7** shall not be considered cost-sharing for purposes of this **Section 2.7.3**; and

2.7.3.5. MassHealth premiums that individuals pay to EOHHS to establish and maintain MassHealth eligibility shall not be considered cost-sharing for purposes of this **Section 2.7.3.**

2.7.4. Primary Care

2.7.4.1. As the manager of care, the Primary Care Provider (PCP) or the PCP's designee shall:

2.7.4.1.1. Provide primary medical services, including acute and preventive care;

2.7.4.1.2. With the Enrollee and the Enrollee's designated representative, if any, develop an ICP;

2.7.4.1.3. For Enrollees requiring Complex Care, implement a comprehensive evaluation process to be performed by an ICT, which will include an in-home or in-facility component. Enrollees with Complex Care needs will have their care managed by an ICT;

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

2.7.4.1.5. Conduct assessments on an ongoing basis in accordance with **Section 2.5** appropriately and as required in this Contract, adjust Individualized Plans of Care as necessary and with Enrollee's knowledge and consent, and communicate the information to the Enrollee's Providers in timely manner;

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

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

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

2.7.4.1.9. 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 2.7.3**); and

2.7.4.1.10. 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.

2.7.5. Pharmacy Management

2.7.5.1. General

2.7.5.1.1. The Contractor shall manage its pharmacy program, including all pharmacy products as described in Appendix C, in accordance with EOHHS requirements in this Contract. For any pharmacy products and activities outside the scope of Part D, EOHHS requirements solely apply [https://www.mass.gov/doc/pharmacy-regulations/download].

2.7.5.2. Management and Support

2.7.5.2.1. The Contractor shall:

2.7.5.2.1.1. Dedicate a clinical pharmacist to oversee the program and shall provide additional pharmacy staffing as necessary to support the provisions of this Contract;

2.7.5.2.1.2. Establish and maintain a call center to answer questions and provide support to pharmacy Providers and to prescribers.

2.7.5.2.1.3. Maintain a telephone reporting system for drug utilization review (DUR) programs that tracks the number of calls, call response time, call duration and abandoned calls, and utilize the tracking system to manage the telephone system. The Contractor shall report on these metrics in accordance with **Appendix A**;

2.7.5.2.1.4. Ensure the following standards are met for calls received by the call center:

2.7.5.2.1.4.1. An abandoned call rate of less than 5%

2.7.5.2.1.4.2. An average speed of calls answered at less than 30 seconds; and

2.7.5.2.1.4.3. An average call handling time, including the time spent on hold, at less than 5 minutes.

2.7.5.2.1.5. Promptly notify EOHHS in the event it will be unable to meet these specifications due to call center volumes greater than 9,000 per month; and

2.7.5.2.1.6. Conduct internal quality assurance on the Contractor's call center.

2.7.5.2.1.7. If the Contractor uses a pharmacy benefit manager (PBM) to assist with the Contractor's prescription drug management program, the Contractor shall follow all requirements with respect to Material Subcontractors set forth in this Contract, including but not limited to those set forth in **Section 2.3**.

2.7.5.3. Drug Coverage

2.7.5.3.1. The Contractor shall:

2.7.5.3.1.1. As described in **Appendix C**, cover all prescription drugs, Non-Drug Pharmacy Products, and over-the-counter drugs uniformly with how EOHHS covers such drugs and products for MassHealth Fee-For-Service Members as set forth in the MassHealth Drug List, and any updates thereto in the timeframe specified by EOHHS, including but not limited to the drugs and products themselves and any utilization management and authorization requirements for such drugs and products.

2.7.5.3.1.2. Operate and maintain a National Council for Prescription Drug Programs (NCPDP)-compliant, online pharmacy claims processing system. Such system shall allow for:

2.7.5.3.1.2.1. Financial, eligibility, and clinical editing of claims;

2.7.5.3.1.2.2. Messaging to pharmacies;

2.7.5.3.1.2.3. Downtime and recovery processes;

2.7.5.3.1.2.4. Electronic prescribing;

2.7.5.3.1.2.5. Electronic prior authorization; and

2.7.5.3.1.2.6. Separate BIN, PCN, and group number combination for each of Medicare primary claims and MassHealth claims, and to differentiate them from claims for other MassHealth programs (if applicable), and from commercial claims. The Contractor shall immediately notify EOHHS of any changes to BIN, PCN, and group number combinations.

2.7.5.3.1.3. Provide outpatient drugs pursuant to this **Section 2.7** in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including but not limited to complying with

all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

2.7.5.3.1.4. Integrate medical claims information to make pharmacy prior authorization decisions at the point of sale.

2.7.5.4. Clinical Management

2.7.5.4.1. The Contractor shall:

2.7.5.4.1.1. Have appropriate processes in place to clinically manage all prescription drugs, over-the-counter drugs, and Non-Drug Pharmacy Products consistent with **Section 2.7** and the MassHealth Drug List, unless otherwise specified by EOHHS.

2.7.5.4.1.2. Provide electronic access to the MassHealth Drug List by linking the MassHealth Drug List on the Contractor's website.

2.7.6. Health Promotion and Wellness Activities

2.7.6.1. The Contractor shall 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 shall be relevant to the specific health-status needs and high-risk behaviors in the senior population. Interpreter services shall 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:

2.7.6.1.1. Exercise;

2.7.6.1.2. Preventing falls;

2.7.6.1.3. Adjustment to illness-related changes in functional ability;

2.7.6.1.4. Adjustment to changes in life roles;

2.7.6.1.5. Smoking cessation;

2.7.6.1.6. Nutrition;

2.7.6.1.7. Prevention and treatment of alcohol and substance abuse; and

2.7.6.1.8. Coping with Alzheimer's disease or other forms of dementia.

2.7.6.2. Whenever possible and appropriate, the Contractor shall use Community Health Workers to provide health promotion and wellness

information to Enrollees, including as described in **Sections 2.7.10** and **2.10.5**.

2.7.7. Behavioral Health

2.7.7.1. Continuum of Behavioral Health Care

2.7.7.1.1. The Contractor shall offer a continuum of behavioral health care as defined in **Appendix C** that is coordinated with PCPs or ICTs, or other Members of the care team as appropriate.

2.7.7.2. Coordination of Medication

2.7.7.2.1. Prescriptions for any psychotropic medications shall be evaluated for interactions with the medications already prescribed for the Enrollee.

2.7.7.3. Behavioral Health Responsibilities

2.7.7.3.1. The Contractor shall manage the provision of all behavioral health services. When services for Emergency Medical Conditions are needed, the Enrollee may seek care from any qualified behavioral health Provider.

2.7.7.3.2. The care management protocol for Enrollees shall encourage appropriate access to behavioral health care covered services in **Appendix C** in all settings, including those listed in **Appendix G**.

2.7.7.3.3. For Enrollees who require behavioral health services, the behavioral health Provider shall:

2.7.7.3.3.1. With the Enrollee and the Enrollee's designated representative, if any, develop the behavioral health portion of the ICP for each Enrollee in accordance with accepted clinical practice;

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

2.7.7.3.3.3. With Enrollee consent and per Enrollee preferences documented in the Comprehensive Assessment, make appropriate and timely entries into the CER about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and ICP developed. As stated in **Section 2.15.5.6.2.7**, psychotherapeutic session notes shall not be recorded in the CER; and

2.7.7.3.3.4. Obtain authorization, as appropriate, for any non-emergency services, except when authorization is specifically not required under this Contract.

2.7.7.4. Services for Enrollees with serious and persistent mental illness

2.7.7.4.1. The Contractor shall ensure that Enrollees with serious and persistent mental illness have access to services in keeping with the recovery principles. For such Enrollees, a qualified behavioral health clinician shall be part of the ICT. As necessary, care coordination with DMH and its contracted programs that serve the Enrollee shall be provided.

2.7.7.4.2. The Contractor and providers shall comply with the Mental Health Parity and Addiction Equity Act of 2008, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

2.7.7.4.3. The Contractor shall 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 shall proactively coordinate and follow Enrollee progress through the continuum of care.

2.7.7.4.4. The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services as most recently adopted by the American Medical Association and CMS.

2.7.7.5. Substance Use Disorder Services

2.7.7.5.1. In accordance with Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, and consistent with other applicable Contract requirements, the Contractor shall have in place the following with respect to its drug utilization review (DUR) program in a manner compliant with the requirements set forth in such act:

2.7.7.5.1.1. Safety edits, including but not limited to, as further directed by EOHHS:

2.7.7.5.1.1.1. Having safety edits in place that include prior authorization when the accumulated daily morphine

equivalents for an individual exceeds the maximum amount allowed by the state, quantity limits, early refill rules, duplicate and overlap restrictions; and

2.7.7.5.1.1.2. Implementing a safety edit for concurrent chronic use of opioids and benzodiazepines and review automated processes.

2.7.7.5.1.2. A program to monitor antipsychotic medications, including but not limited to, as further directed by EOHHS:

2.7.7.5.1.2.1. Having a method to monitor and report on concurrent chronic use of opioids and antipsychotics;

2.7.7.5.1.2.2. Fraud and abuse identification requirements, including but not limited to, having a process that identifies potential fraud or abuse by Enrollees, health care providers, and pharmacies;

2.7.7.5.1.2.3. Any required claims review automated processes; and

2.7.7.5.1.2.4. Retrospective reviews on opioid prescriptions to address duplicate fill and early fill alerts, quantity limits, dosage limits, and morphine milligram equivalents limitations.

2.7.8. Emergency, Urgent, and 24/7 Provider Access

2.7.8.1. 24-Hour Service Access

2.7.8.1.1. The Contractor shall follow Federal and State regulations about twenty-four (24) hour service in accordance with 42 C.F.R. § 438.206(c)(1)(iii) and 42 C.F.R. § 422.112(a)(7)(ii), making Covered Services available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

2.7.8.1.2. The Contractor shall ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community through the Contractor's Provider Network. The Contractor shall:

2.7.8.1.2.1. Have a process established to notify the PCP (or the designated covering physician) and other appropriate physical health, LTSS, or BH providers, and any additional ICT Members of an Emergency Medical Condition within one business day after the Contractor is notified by the provider. If the Contractor is not notified by the provider within ten (10) calendar days of the Enrollee's presentation for Emergency

Services, the Contractor may not refuse to cover Emergency Services.

2.7.8.1.2.2. Have a process to notify the PCP and other appropriate physical health, LTSS, or BH providers, and any additional ICT Members of required Urgent Care within twenty-four (24) hours of the Contractor being notified.

2.7.8.1.2.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Centralized Enrollee Record no more than 18 hours after the PCP or ICT is notified, and a full report of the services provided within two business days.

2.7.8.1.2.4. If the Contractor's network is unable to provide necessary medical services to an Enrollee, the Contractor shall adequately and timely cover these services for the Enrollee for as long as the Contractor's network is unable to provide them. This shall be done within sixty (60) calendar days after the claim has been submitted. The Contractor shall ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network and Enrollees are afforded all protections against balance billing by providers.

2.7.8.1.3. When an Enrollee is involved with one or more EOHHS agency the Contractor shall notify such agencies of an Enrollee's admission to an inpatient facility within one (1) business day of the facility's admission notification with respect to such Enrollee.

2.7.8.1.4. The Contractor shall authorize other non-network services to promote access and continuity of care.

2.7.8.2. Emergency and Post-stabilization Care Coverage

2.7.8.2.1. The Contractor's Provider Network shall comply with the Emergency Medical Treatment and Labor Act (EMTALA), which requires:

2.7.8.2.1.1. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b);

2.7.8.2.1.2. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers;

2.7.8.2.1.3. The Contractor's contracts with its providers shall clearly state the provider's EMTALA obligations and shall not create any conflicts with hospital actions required to comply with EMTALA.

2.7.8.2.2. The Contractor shall cover and pay for Emergency Services and any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c) and Massachusetts General Laws chapter 118E, Section 17A.

2.7.8.2.3. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor.

2.7.8.2.4. The Contractor shall not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R §§ 438.114(a) of the definition of emergency medical condition,

2.7.8.2.5. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

2.7.8.2.6. The Contractor shall not deny payment for treatment of an Emergency Medical Condition if a representative of the Contractor instructed the Enrollee to seek Emergency Services.

2.7.8.2.7. The Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms.

2.7.8.2.8. The Contractor shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment but may not refuse to cover Emergency Services based on their failure to do so.

2.7.8.2.9. The Contractor shall ensure that an Enrollee who has an Emergency Medical Condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.7.8.2.10. The attending emergency physician, or the provider actually treating the Enrollee for an Emergency Medical Condition, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor responsible for coverage and payment.

2.7.8.2.11. The Contractor shall cover and pay for Post stabilization Care Services in accordance with 42 C.F.R. § 438.114(b) and (e), 42 CFR 422.113(c)(2) and (3), and M.G.L. c. 118E, § 17A.

2.7.8.2.12. The Contractor's Provider Network shall comply with the Emergency Medical Treatment and Labor Act (EMTALA), which requires:

2.7.8.2.12.1. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b).

2.7.8.2.12.2. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

2.7.8.2.12.3. The Contractor's contracts with its providers shall clearly state the provider's EMTALA obligations and shall not create any conflicts with hospital actions required to comply with EMTALA.

2.7.8.3. Comparable FFS Payment for Non-Network Providers

2.7.8.3.1. To the extent non-network Medicare payment provisions apply to the Contractor for activities described in **Sections 2.7.8.1** and **2.7.8.2** above, the Contractor shall be advised that for a Provider of a Medicare Service serving a Dual Eligible Individual with Original Medicare and MassHealth FFS, the amount such Provider would receive would be limited to the MassHealth FFS fee schedule when such fee schedule is less than the applicable Medicare fee schedule.

2.7.8.4. 24/7 Clinical Advice Line

2.7.8.4.1. The Contractor shall provide a twenty-four (24) hours-per-day, seven (7) days-per-week toll-free telephone system with access to a registered nurse or similarly licensed and qualified skilled health care professional who:

2.7.8.4.1.1. Has immediate access to the Centralized Enrollee Record,

2.7.8.4.1.2. Is able to respond to Enrollee questions about health or medical concerns,

2.7.8.4.1.3. Has the experience and knowledge to provide clinical triage,

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

2.7.8.4.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge.

2.7.9. Long-term Services and Supports (LTSS)

2.7.9.1. LTSS Delivery System

2.7.9.1.1. In delivering the Covered Services defined in Appendix C that relate to LTSS, the Contractor shall demonstrate the capacity to provide coordination of care and expert care management through the ICT. The Contractor shall ensure that:

2.7.9.1.1.1. The GSSC executes the responsibilities described in **Section 2.6**;

2.7.9.1.1.2. The ICT arranges, delivers, and monitors long-term care services on an ongoing basis; and

2.7.9.1.1.3. The measurement of the Functional Status of Enrollees is performed in Assessments as specified in **Section 2.5.2**. Reports will be produced in accordance with **Appendix A**.

2.7.9.1.2. The Contractor shall have a process in place to alert and engage the Enrollee's Care Coordinator (internal or contracted) of any determination that a requested Long-term Service or Support would be denied or partially denied as the result of prior authorization, utilization management, or other evaluation. This engagement with the Enrollee's Care Coordinator shall occur before a final denial, partial denial, or reduction action is effectuated, except where a request for expedited service authorization has been made as described in **Section 2.10.9.8.2** and it is not possible to alert and engage the Care Coordinator in advance due to timeliness requirements. In this circumstance, the Care Coordinator shall be alerted and engaged regarding any denial or partial denial immediately after the determination and notification to the Member is made.

2.7.9.2. Continuum of Long-term Care

2.7.9.2.1. The Contractor Shall arrange and pay for:

2.7.9.2.1.1. Community alternatives to institutional care,

2.7.9.2.1.2. Other transitional, respite, and support services to maintain Enrollees safely in the community, based on assessment by

the Contractor of Functional Status, Functional need, and cost effectiveness of the services being requested,

2.7.9.2.1.3. Nursing facility services for both short-term and long-term stays as described in **Appendix C** for Enrollees who:

2.7.9.2.1.3.1. Meet applicable screening requirements (in accordance with 130 CMR Chapter 456 and Chapters 515 through 524);

2.7.9.2.1.3.2. Desire such services (see **Appendix A** for reporting requirements);

2.7.9.2.1.3.3. For whom the Contractor has no community service package appropriate and available to meet the Enrollee's medical needs; and

2.7.9.2.1.3.4. Other institutional services as determined by the ICT.

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

2.7.9.3.1. The Contractor shall 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. Among other things, the Contractor shall not pay for nursing facility services rendered to an Enrollee during a period in which the nursing facility has failed to comply with PASRR with respect to that Enrollee. In any instance in which the Contractor denies payment in accordance with this Section, in addition to any prohibitions on balance-billing set forth in this Contract (including **Section 5.1.10**), the Contractor shall ensure that the Provider does not attempt to bill the Enrollee for such services.

2.7.10. Community Health Workers

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

2.7.10.1.1. Wellness coaching to engage the Enrollee in prevention activities such as smoking cessation, exercise, diet, and obtaining health screenings;

2.7.10.1.2. Evidence based practices and techniques for chronic disease self-management;

2.7.10.1.3. Qualified peer support for Enrollees with mental health and/or substance use disorders to assist such Enrollees in their recovery, for Enrollees with physical disabilities or other functional limitations to assist such Enrollees in the pursuit of maintaining independence, or for Enrollees coping with aging related issues and challenges; and

2.7.10.1.4. Community supports for newly housed Enrollees who are experiencing homelessness, have recently experienced homelessness, or who are at risk of homelessness.

2.7.10.2. Community Health Workers shall be available and appropriate for the populations served, such as for Enrollees who are Deaf or hard of hearing.

2.7.11. Additional Requirements

2.7.11.1. The Contractor shall deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.

2.7.11.2. The Contractor shall provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery systems, the Contractor shall respect the Privacy of Enrollees. The Contractor shall comply with **Section 5.2** regarding compliance with laws and regulations relating to confidentiality and Privacy.

2.7.12. Service Codes

2.7.12.1. As directed by EOHHS, the Contractor shall cover and use the service codes provided by, and as updated by, EOHHS representing the SCO Covered Services set forth in **Appendix C**.

2.7.12.2. The Contractor shall also use such codes provided by EOHHS to describe services other than Covered Services.

2.8. Provider Network, Contracts, and Related Responsibilities

2.8.1. Provider Network

2.8.1.1. General

2.8.1.1.1. The Contractor shall maintain and monitor a Provider Network sufficient to provide all Enrollees, including those with limited English

proficiency or physical or mental disabilities, with meaningful access to the full range of Covered Services, including Behavioral Health, Oral Health, LTSS, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206(b)(1) and under this Contract (see Covered Services in **Appendix C**). As further directed by EOHHS, the Contractor shall maintain information about its Provider Network with respect to the above requirement and provide EOHHS with such information upon request.

2.8.1.1.2. The Provider Network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract, including all entities listed on **Appendix G**.

2.8.1.1.2.1. When directed by EOHHS, such Providers shall be enrolled with EOHHS as specified by EOHHS in accordance with 42 CFR 438.602(b), and

2.8.1.1.2.2. The Contractor shall comply with 42 CFR 438.602(b)(2) and therefore may execute Provider Contracts for up to 120 days pending the outcome of EOHHS's enrollment process but shall terminate a Provider Network immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider. The Contractor shall notify affected Enrollees of the termination.

2.8.1.1.2.3. The Contractor shall notify EOHHS of any significant Provider Network changes immediately, with the goal of providing notice to EOHHS at least 60 days prior to the effective date of any such change.

2.8.1.1.3. The Contractor shall comply with the requirements specified in 42 C.F.R. § 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.8.1.1.4. The Contractor shall make best efforts to ensure that businesses and organizations certified under 425 CMR 2.00 are represented in the Provider Network. The Contractor shall submit annually the appropriate certification checklist on its efforts to contract with such-certified entities (see **Appendix A**).

2.8.1.1.5. In establishing and maintaining the Provider Network, the Contractor shall consider the following:

2.8.1.1.5.1. The anticipated number of Enrollees;

2.8.1.1.5.2. The expected utilization of services, taking into consideration the cultural and ethnic diversity, demographic characteristics, communication requirements, and health care needs of specific populations enrolled with the Contractor;

2.8.1.1.5.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;

2.8.1.1.5.4. The number of Network Providers who are not accepting new patients; and

2.8.1.1.5.5. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.

2.8.1.1.6. The Contractor shall demonstrate through reports specified in **Appendix A** that its provider network offers an appropriate range of preventive, primary care, specialty services, behavioral health, community-based services, Oral Health, and LTSS that is sufficient in number, mix, geographic distribution, and competencies to adequately meet the needs of the anticipated number of Enrollees in its Service Area, as described in **Section 2.9**.

2.8.1.1.7. The Contractor shall not establish selection policies and procedures for providers that discriminate against providers that serve high risk populations or specialize in conditions that require costly treatment.

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

2.8.1.1.9. The Contractor’s Provider Network shall include freestanding birth centers licensed by the Commonwealth of Massachusetts Department of Public Health.

2.8.1.1.10. 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.

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

2.8.1.1.12. The Contractor shall demonstrate to EOHHS, including through submission of reports as may be requested by EOHHS, use of Alternative Payment Methodologies that will advance the delivery system innovations inherent in the Commonwealth's integrated care plans, incentivize quality care, health equity, and improve health outcomes for Enrollees. The Contractor shall comply with the requirements of M.G.L. Chapter 224, Section 261 of the Acts of the 2012. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w 111, Sec. 1860D 11(i).

2.8.1.1.13. The Contractor shall ensure that its Network Providers and Material Subcontractors meet all current and future state and federal eligibility criteria, (e.g., not contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act and implementing regulations at 42 C.F.R. Part 1001 et. Seq) and submit standard and ad hoc reporting requirements, and any other applicable rules and/or regulations related to this Contract.

2.8.1.1.14. As directed by EOHHS, the Contractor shall comply with any moratorium, numerical cap, or other limit on enrolling new Providers or suppliers imposed by EOHHS or the U.S. Department of Health and Human Services.

2.8.1.2. Required State Agency Providers

2.8.1.2.1. The Contractor shall contract with all inpatient hospitals, outpatient hospitals, and community mental health centers that are operated by DMH and DPH in **Appendix G**.

2.8.1.2.2. Additionally, as further specified by EOHHS, the Contractor shall include in its Provider Network the state agency providers set forth in **Appendix G**, **Exhibit 3** identified as providing Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS) as described in **Appendix C, Exhibit 2**.

2.8.1.2.3. The Contractor shall not require the state agency providers described in this **Section 2.8.1.2** to indemnify the Contractor, to hold a license, or to maintain liability insurance, and

2.8.1.2.4. If required by EOHHS, the Contractor shall include in its Provider Network or pay as non-network providers, other state agency providers as set forth in **Appendix G**.

2.8.1.3. Non-Network Access

2.8.1.3.1. The Contractor shall ensure that best efforts are made to contact and contract with non-network providers, including, within the first ninety (90) days of an Enrollee's Membership in the Contractor's SCO Plan, such providers and prescribers which are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-Network Providers. If the provider does not join the network, or if the Enrollee does not select a new in Network Provider by the end of the ninety (90) day period or after the Individualized Care Plan is developed, the Contractor shall choose one for the Enrollee.

2.8.1.3.2. The Contractor shall not deny authorization of Medically Necessary Services due to insufficient appropriate in-network access to such services.

2.8.1.3.3. If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor shall adequately and timely cover these services through non-network providers for the Enrollee, for as long as the Contractor is unable to provide them. No cost-sharing is allowed in this circumstance.

2.8.1.3.4. The Contractor shall maintain and utilize protocols to address situations when the Provider Network is unable to provide an Enrollee with appropriate access to Covered Services or medical diagnostic equipment due to lack of a qualified Network Provider or medical diagnostic equipment within reasonable travel time of the Enrollee's residence as defined in **Section 2.10**, or that is not otherwise accessible to the Enrollee. The Contractor's protocols shall ensure best efforts to resolve an Enrollee's access to care need, whether through single case agreements, contracting with new providers, fully covering access to a non-network provider, or through other methods. The Contractor's protocols shall ensure, at a minimum, the following:

2.8.1.3.4.1. If the Contractor is unable to provide a particular Covered Service or medical diagnostic equipment through its Provider Network, it will be adequately covered in a timely way through non-network providers;

2.8.1.3.4.2. When accessing a non-network provider, the Enrollee is able to obtain the same service or to access a provider with the same type of training, experience, and specialization as within the Provider Network;

2.8.1.3.4.3. That non-network providers shall coordinate with the Contractor with respect to payment, ensuring that the cost to

the Enrollee is no greater than it would be if the services were furnished through the Provider Network;

2.8.1.3.4.4. That the particular service will be provided by the most qualified and clinically appropriate provider available;

2.8.1.3.4.5. That the provider will be located within the shortest travel time of the Enrollee's residence; taking into account the availability of public transportation to the location;

2.8.1.3.4.6. That the provider will be informed of their obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in their primary language;

2.8.1.3.4.7. That the only Provider available to the Enrollee in the Provider Network does not, because of moral or religious objections, decline to provide the service the Enrollee seeks;

2.8.1.3.4.8. That consideration is given for a non-network option in instances in which the Enrollee's Provider(s) determines that the Enrollee needs a service, and that the Enrollee would be subjected to unnecessary risk if the Enrollee received those services separately and not all of the related services are available within the Provider Network;

2.8.1.3.4.9. That the Contractor cover services furnished in another state in accordance with 42 CFR 431.52(b) and 130 CMR 450.109; and

2.8.1.3.4.10. That the Contractor complies with **Section 2.7**.

2.8.1.3.5. The Contractor shall report on its use of non-network providers to meet Enrollee's necessary medical service needs as required in **Appendix A**.

2.8.1.3.6. If the Contractor declines to include individuals or groups of providers in its Provider Network, the Contractor shall give the affected providers written notice of the reason for its decision.

2.8.1.3.7. The Provider Network shall be responsive to the linguistic, cultural, and other individual needs of any Enrollee, person experiencing homelessness, transgender or gender-diverse persons, or other special populations served by the Contractor by, at a minimum, including the capacity to communicate with Enrollees in languages other than English, communicate with individuals who are Deaf, hard of hearing or deaf blind.

2.8.1.4. Additional Provider Network Requirements for Behavioral Health Services

2.8.1.4.1. The Contractor shall ensure that its Behavioral Health Provider Network includes an adequate number of Providers with experience and expertise in various specialty areas described below. In addition to ensuring its Network includes Behavioral Health Providers who can address all Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM 5) (or current version as applicable) diagnostic needs as described in the most recent publication, the Contractor shall ensure that its Behavioral Health Provider Network has expertise in at least the following:

2.8.1.4.1.1. Co-Occurring Disorders;

2.8.1.4.1.2. Serious and persistent mental illness;

2.8.1.4.1.3. Physical disabilities and chronic illness;

2.8.1.4.1.4. Deaf and hard of hearing and blind or visually impaired;

2.8.1.4.1.5. HIV/AIDS;

2.8.1.4.1.6. Homelessness;

2.8.1.4.1.7. Post-traumatic stress disorder;

2.8.1.4.1.8. Fire-setting behaviors;

2.8.1.4.1.9. Sex-offending behaviors;

2.8.1.4.1.10. Substance use disorders;

2.8.1.4.1.11. Eating Disorders;

2.8.1.4.1.12. Gender dysphoria; and

2.8.1.4.1.13. Criminal justice involvement.

2.8.1.4.2. The Contractor shall allow independently practicing clinicians with the following licenses to apply to become Network Providers: Licensed Independent Clinical Social Worker (LICSW), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC) and Licensed Psychologist;

2.8.1.4.3. The Contractor shall permit Enrollees to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Services and to change Behavioral Health Providers at any time;

2.8.1.4.4. The Contractor shall require all Providers to provide an Enrollee's clinical information to other Providers, as necessary, to ensure proper coordination and behavioral health treatment of Enrollees who express suicidal or homicidal ideation or intent, consistent with state law;

2.8.1.4.5. For Behavioral Health Inpatient and 24-hour Diversionary Services, the Contractor shall:

2.8.1.4.5.1. Ensure that all Behavioral Health Inpatient and 24-hour Diversionary Services Provider Contracts require the Behavioral Health Inpatient and 24-hour Diversionary Services Provider accept for admission or treatment all Enrollees for whom the Contractor has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age-appropriate unit;

2.8.1.4.5.2. Promote continuity of care for Enrollees who are readmitted to Behavioral Health Inpatient and 24-hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility;

2.8.1.4.5.3. Require Behavioral Health Inpatient and 24-hour Diversionary Services Providers to coordinate treatment and Discharge Planning with the state agencies (e.g., DMH, DDS) with which the Enrollee has an affiliation, and that in no such case shall Providers discharge patients who are homeless or who have unstable housing without a plan for housing;

2.8.1.4.5.4. Ensure that all Behavioral Health Inpatient and 24-hour Diversionary Services Providers have:

2.8.1.4.5.4.1. Human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations and include training of the Provider's staff and education for Enrollees regarding human rights; and

2.8.1.4.5.4.2. A human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Enrollees regarding their human rights, in accordance with DMH's Human Rights and Restraint and Seclusion Policy and with applicable DMH regulations and requirements;

2.8.1.4.5.5. Require that Behavioral Health Inpatient and 24-hour Diversionary Services Providers coordinate with all

contracted CBHCs in the Contractor's Service Area(s), including procedures to credential and grant admitting privileges to AMCI Provider psychiatrists, if necessary; and

2.8.1.4.5.6. As needed, participate in or convene regular meetings and conduct ad hoc communication on clinical and administrative issues with CBHCs to enhance the continuity of care for Enrollees.

2.8.1.4.6. As directed by EOHHS, the Contractor shall contract with a network of Providers to provide Behavioral Health Emergency Screening, Community Behavioral Health Centers (CBHCs), and Adult Mobile Crisis Intervention Services.

2.8.1.5. CBHC Contracts

2.8.1.5.1. The Contractor shall:

2.8.1.5.1.1. Execute and maintain contracts with the CBHCs identified in **Appendix G** of this Contract, as updated by EOHHS from time to time, to provide all CBHC services, including AMCI services as set forth in **Appendix C**, as applicable, to this Contract;

2.8.1.5.1.2. Implement performance specifications as specified by EOHHS, and ensure compliance with such specifications;

2.8.1.5.1.3. Not require CBHCs to obtain prior authorization for any services provided by CBHCs;

2.8.1.5.1.4. Provide payment for services provided by such CBHCs to Enrollees; and

2.8.1.5.1.5. As directed by EOHHS, take all steps and perform all activities necessary to execute contracts with CBHCs and support the successful implementation and operations of the CBHC program, including, without limitation, participation in meetings and workgroups, the development and implementation of new Enrollee access to AMCI provided by CBHCs.

2.8.1.5.2. Enrollee Access to Behavioral Health AMCI Provided by CBHCs

2.8.1.5.2.1. The Contractor shall:

2.8.1.5.2.1.1. Establish policies and procedures to make best efforts to ensure that all Enrollees receive AMCI provided by a CBHC or hospital ED-based crisis evaluation services

prior to hospital admissions for Inpatient Mental Health Services to ensure that Enrollees have been evaluated for diversion or referral to the least restrictive appropriate treatment setting;

2.8.1.5.2.1.2. Permit Enrollees access to Behavioral Health Services provided by CBHCs through direct self-referral, the BH Help Line, the Contractor's toll-free telephone line, or referral by family members or guardians, individual practitioners, PCPs, or community agencies or hospital emergency departments;

2.8.1.5.2.1.3. Require that the response time for face-to-face crisis evaluations by CBHCs does not exceed one hour from notification by telephone from the referring party or from the time of presentation by the Enrollee;

2.8.1.5.2.1.4. Have policies and procedures to monitor Enrollee access to CBHCs and, as requested by EOHHS and in accordance with **Appendix A**, report, in a form and format as specified by EOHHS, about such access; and

2.8.1.5.2.1.5. If needed, authorize Medically Necessary BH Covered Services within 24 hours following an AMCI encounter.

2.8.1.5.3. CBHC Policies and Procedures

2.8.1.5.3.1. The Contractor shall:

2.8.1.5.3.1.1. In coordination with EOHHS's reporting and oversight, have policies and procedures to monitor CBHCs' performance with respect to established diversion and inpatient admission rates;

2.8.1.5.3.1.2. Have policies and procedures to monitor the CBHCs' performance with respect to diverting encounters with Enrollees from hospital emergency departments to the CBHCs' community-based locations or other community settings;

2.8.1.5.3.1.3. At the direction of EOHHS, identify and implement strategies to maximize utilization of community-based diversion services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with Medical Necessity criteria. Such strategies shall support Providers in shifting utilization from hospital EDs to community-based settings;

2.8.1.5.3.1.4. Have policies and procedures regarding the circumstances under which CBHCs shall contact the Contractor for assistance in securing an inpatient or 24-hour Diversionary Service placement. Such policies and procedures shall include that if a CBHC requests the Contractor's assistance in locating a facility that has the capacity to timely admit the Enrollee, the Contractor shall contact Network Providers to identify such a facility or, if no appropriate Network Provider has such capacity, shall contact non-network Providers to identify such a facility;

2.8.1.5.3.1.5. At the direction of EOHHS, participate in development of policies and procedures to ensure collaboration between CBHCs, Network Providers, and DMH area and site offices in the geographic area they serve;

2.8.1.5.3.1.6. Have a plan in place to direct Enrollees to the least intensive but clinically appropriate service;

2.8.1.5.3.1.7. Have a process to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including coordination with DMH's Expedited Psychiatric Inpatient Admissions (EPIA) Team when applicable;

2.8.1.5.3.1.8. Utilize standardized documents such as risk management/safety plans as identified by EOHHS;

2.8.1.5.3.1.9. Convene meetings to address clinical and administrative issues with CBHCs and to enhance the coordination of care for Enrollees;

2.8.1.5.3.1.10. Attend statewide meetings regarding CBHCs and services provided by CBHCs, as convened by EOHHS and/or EOHHS's Behavioral Health contractor;

2.8.1.5.3.1.11. Ensure that contracted CBHCs utilize, as is necessary, the statewide Massachusetts Behavioral Health Access website or other required tracking method;

2.8.1.5.3.1.12. Ensure that, upon request of a court clinician conducting a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e):

2.8.1.5.3.1.12.1. CBHCs provide Crisis Assessment and Intervention to Enrollees, identify to the court

clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions, and

2.8.1.5.3.1.12.2. If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), and the CBHC determines that such admission is Medically Necessary, the CBHC conducts a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order.

2.8.1.5.4. Medication for Opioid Use Disorder (MOUD) Services

2.8.1.5.4.1. The Contractor shall ensure that Enrollees have access to MOUD Services, including initiation and continuation of MOUD, and ensure that Enrollees receive assistance in accessing such services.

2.8.1.5.4.2. The Contractor shall include in its Provider Network, qualified Providers to deliver MOUD Services, by at a minimum, as further directed by EOHHS, and in accordance with all other applicable Contract requirements, offering Network Provider agreements at a reasonable rate of payment to:

2.8.1.5.4.2.1. All Office Based Opioid Treatment (OBOT) providers as specified by EOHHS; and

2.8.1.5.4.2.2. All Opioid Treatment Program (OTP) providers as specified by EOHHS.

2.8.1.5.4.3. The Contractor shall ensure that all such Providers of MOUD Services coordinate and integrate care with Enrollees' PCPs and other Providers in response to Enrollees' needs;

2.8.1.5.4.4. As further directed by EOHHS, the Contractor shall ensure Enrollees may receive MOUD Services through qualified PCPs in the Provider Network; and

2.8.1.5.4.5. The Contractor shall not require an authorization or referral for MOUD Services, unless otherwise directed by EOHHS.

2.8.2. Provider Contracts

2.8.2.1. General

2.8.2.1.1. The Contractor shall maintain all Provider Contracts and other agreements and subcontracts relating to this Contract, including agreements with non-network providers, in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 CFR Part 438 and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the Contractor shall ensure that all Provider Contracts and contracts with non-network providers include the following provision: “Providers shall not seek or accept payment from any Enrollee for any Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any Covered Service rendered to an Enrollee. Instead, Providers shall look solely to the [Contractor’s name] for payment with respect to Covered Services rendered to Enrollees. Furthermore, Providers shall not maintain any action at law or in equity against any Enrollee or EOHHS to collect any sums that are owed by the [Contractor’s name] under the Contract for any reason, even in the event that the [Contractor’s name] fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where “Contract” refers to the agreement between the Contractor and any Network Providers and non-Network Providers).” The Provider Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

2.8.2.1.2. The Contractor shall actively monitor the quality of care provided to Enrollees under any Provider Contracts and Material Subcontracts.

2.8.2.1.3. The Contractor shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations. All such written communications shall be subject to review at EOHHS’s discretion.

2.8.2.1.4. Require a National Provider Identifier on all claims and provider applications.

2.8.2.1.5. The Contractor shall not include in its Provider Contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any provider network other than the Contractor’s Provider Network(s).

2.8.2.1.6. With respect to all Provider Contracts, comply with 42 CFR 438.214, including complying with any additional requirements as specified by EOHHS.

2.8.2.2. Additional Standards for Provider Contracts and Other Agreements with Providers

2.8.2.2.1. All such Provider Contracts and agreements, including single case agreements, with non-network providers shall:

2.8.2.2.1.1. Be in writing;

2.8.2.2.1.2. Contain, at a minimum, the provisions described in this Section; and

2.8.2.2.1.3. Comply with all applicable provisions of this Contract.

2.8.2.2.2. The Contractor shall ensure that all Provider Contracts prohibit Providers from:

2.8.2.2.2.1. Billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such Provider Contracts shall require Providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments;

2.8.2.2.2.2. Billing patients for charges for Covered Services;

2.8.2.2.2.3. Refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member; and

2.8.2.2.2.4. Closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees.

2.8.2.3. Cultural and Linguistic Competence

2.8.2.3.1. The Contractor and their Network Providers shall participate in any EOHHS efforts to promote the delivery of services in a culturally competent manner to all Enrollees that is sensitive to age, gender, gender identity, sexual orientation, cultural, linguistic, racial, ethnic, and religious backgrounds, and congenital or acquired disabilities.

2.8.2.3.2. The Contractor shall ensure that they contract with multilingual Network Providers to the extent that such capacity exists in the Contractor’s Service Area and ensure that all Network Providers understand and comply with their obligations under State or Federal law

to assist Enrollees with skilled medical interpreters and identify the resources that are available to assist Network Providers to meet these obligations.

2.8.2.3.3. The Contractor shall ensure that Network Providers and interpreters/translators, either in person or though video relay technology, are available for those who are Deaf or hard of hearing.

2.8.2.3.4. The Contractor shall ensure that its Network Providers have a strong understanding of aging, substance use disorder recovery culture, and LTSS.

2.8.2.4. Provider Low Claims Volume

2.8.2.4.1. The Contractor shall identify Primary Care, Specialty, and BH Network Providers included in the Contractor's Provider Directory who have not submitted at least two claims for BH Covered Services to Enrollees in the past 12 months, and report on such Providers to EOHHS as specified in Appendix A. EOHHS may require the Contractor to determine if Enrollees have meaningful access to these Providers, and if such Providers should remain in the Contractor's Provider Directory.

2.8.2.4.2. Contractor shall identify and contact by August 31, 2025, and annually thereafter all Providers who billed fewer than fifty services in the previous Contract Year to determine capacity and to assist them with expanding their reach and to assist and encourage them to provide services to a more Members. Contractor shall document these efforts. Contractor shall report a list of such Providers to EOHHS by provider type and geographic location, as described in **Appendix A.** Contractor shall examine and describe in its report to EOHHS the extent to which Members have meaningful access to these Dental Providers in the Network, whether these Dental Providers status in Provider Directory as accepting new patients should change, and whether these Dental Provider should remain in the Network access metrics.

2.8.3. Additional Responsibilities for Certain Providers

2.8.3.1. Primary Care Providers (PCPs)

2.8.3.1.1. The Contractor shall ensure contracts with each PCP require the PCP to:

2.8.3.1.1.1. Share clinical data on Enrollees with the Contractor, including but not limited to data to support the Quality Measure reporting requirements described in **Appendix A**, subject to all applicable laws and regulations, as further specified by EOHHS;

2.8.3.1.1.2. Observe and comply with all applicable Enrollee rights and protections in this Contract;

2.8.3.1.1.3. Provide care to Enrollees in accordance with the requirements described in **Section 2.7**, and otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Enrollee's medical record,

2.8.3.1.1.4. Perform, at a minimum, the following activities:

2.8.3.1.1.4.1. Supervising, coordinating and providing care to each assigned Enrollee;

2.8.3.1.1.4.2. Initiating referrals for Medically Necessary specialty care for which the Contractor requires referrals. The Contractor shall require its PCPs to refer Enrollees to Network Providers or, if the PCP refers the Enrollee to a non-network provider, to confirm with the Contractor that the Contractor shall cover the Enrollee seeing that non-network provider and also inform the Enrollee to speak with the Contractor before seeing that non-network provider;

2.8.3.1.1.4.3. Ensuring that Enrollees who are identified as requiring Behavioral Health Services are offered referrals for Behavioral Health Services, when clinically appropriate;

2.8.3.1.1.4.4. Maintaining continuity of care for each assigned Enrollee; and

2.8.3.1.1.4.5. Maintaining the Enrollee's medical record, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty services provided to the Enrollee.

2.8.3.1.1.5. State the Provider may only be terminated for cause.

2.8.3.1.2. The Contractor may develop, implement, and maintain alternative payment methodologies for PCPs and/or Primary Care Practices. Such alternative payment methodologies may be for individual network PCPs or for practices, pods, or other groupings of network PCPs. Such alternative payment methodologies shall:

2.8.3.1.2.1. Be subject to review by EOHHS;

2.8.3.1.2.2. Be implemented in accordance with any guidance or requirements issued by EOHHS; and

2.8.3.1.2.3. Shift financial incentives away from volume-based, Fee-For-Service delivery for PCPs.

2.8.3.1.3. The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty services provided to assigned Enrollees by specialty physicians.

2.8.3.2. Network Hospitals

2.8.3.2.1. The Contractor shall develop, implement, and maintain protocols with each Network hospital that support the coordination of Enrollees' care, including as required in **Section 2.8.3**.

2.8.3.2.2. The Contractor shall ensure that any agreement the Contractor holds with a hospital includes, at a minimum, the following requirements:

2.8.3.2.2.1. Emergency Department (ED) Services

2.8.3.2.2.1.1. The hospital shall notify the Enrollee's PCP, and/or Care Team within one business day of the Enrollee's presentation at a hospital's ED. Notification may include a secure electronic notification of the visit.

2.8.3.2.2.1.2. The hospital shall offer ED-based Behavioral Health crisis evaluation services to all Members presenting with a behavioral health crisis in the ED.

2.8.3.2.2.1.3. The hospital shall offer substance use evaluations, treatment, and notification in the ED in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

2.8.3.2.2.2. Notification of Inpatient Admission and Discharge Planning Activities

2.8.3.2.2.2.1. The hospital shall notify the Enrollee's PCP, and/or Care Team within one business day of the Enrollee's inpatient admission. Notification may include a secure electronic notification of the visit. EOHHS may specify the form and format for such notification.

2.8.3.2.2.2.2. The hospital, when possible, shall begin Discharge Planning on the first day of the Enrollee's inpatient admission.

2.8.3.2.2.2.3. In addition to satisfying all other requirements for Discharge Planning:

2.8.3.2.2.2.3.1. The hospital shall ensure that the hospital's discharge summary is sent to the Enrollee's PCP, and/or Care Team within two business days of the discharge. The discharge summary shall include a copy of the hospital's discharge instructions that were provided to the Enrollee and include details on the Enrollee's diagnosis and treatment.

2.8.3.2.2.2.3.2. The hospital shall notify the Enrollee's PCP and the Contractor in order to ensure that appropriate parties are included in Discharge Planning. Such parties may include care coordinators, case managers, caregivers, and other critical supports for the Enrollee.

2.8.3.2.2.2.3.3. The hospital shall document in the Enrollee's medical record all actions taken to satisfy the notification and Discharge Planning requirements set forth in this **Section 2.6.3**.

2.8.3.2.2.3. A hospital with a DMH-licensed inpatient psychiatric unit shall accept into its DMH-licensed inpatient psychiatric unit all referrals of Enrollees that meet the established admission criteria of the inpatient unit.

2.8.3.2.2.4. The Contractor shall coordinate with DMH for any admissions to and discharges from DMH operated inpatient units.

2.8.3.2.2.5. The hospital shall report all available DMH-licensed beds into the Massachusetts Behavioral Health Access website at a minimum three (3) times per day, seven (7) days per week. Such updates shall occur, at a minimum, between 8am-10am, 12pm-2pm, and 6pm-8pm, or at a time and frequency specified by EOHHS.

2.8.4. Administratively Necessary Day (AND) Status Data

2.8.4.1. As directed by EOHHS, the Contractor shall collect and report data to EOHHS regarding Enrollees on Administratively Necessary Days (AND) status in a twenty-four (24) hour level of care. The Contractor shall report to EOHHS Member-level reporting on a daily basis through the Massachusetts Behavioral Health Access (MABHA) website, as further specified by EOHHS, and additional information on an ad hoc basis in a form, format, and frequency specified by EOHHS.

2.8.5. Provider Payments

2.8.5.1. Timely Payment to Providers

2.8.5.1.1. The Contractor shall make payment on a timely basis to Providers for 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 a contract between the Contractor and a Provider that has been reviewed and approved by EOHHS, the Contractor shall:

2.8.5.1.1.1. Pay 90% of all Clean Claims for Covered Services from Providers within thirty (30) days from the date the Contractor receives the Clean Claim;

2.8.5.1.1.2. Pay 99% of all Clean Claims from Providers within sixty (60) days from the date the Contractor receives the Clean Claim;

2.8.5.1.1.3. Submit a Claims Processing report in accordance with **Appendix A**; and

2.8.5.1.1.4. For the purposes of this Section, the day the Contractor receives the Clean Claim is the date indicated by the date stamp on the claim and the day the Contractor pays the Clean Claim is the date of the check or other form of payment.

2.8.5.2. The Contractor shall not implement any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services.

2.8.5.2.1. The Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

2.8.5.2.2. The Contractor shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

2.8.5.2.3. Nothing in this Section shall be construed to prohibit Provider Contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with **Section 2.8.5.5.2**.

2.8.5.3. EOHHS may, in its discretion, direct the Contractor to establish payment rates for Providers of certain types of services in its Provider Network. EOHHS may require that such payment rates be:

2.8.5.3.1. No greater than a certain percentage of the Original Medicare (FFS) rate, or another payment rate specified by EOHHS;

2.8.5.3.2. No less than a certain percentage of the MassHealth FFS rate or another payment rate specified by EOHHS; or

2.8.5.3.3. EOHHS may approve exemptions from such requirements, such as to allow for implementation of an alternative payment methodology.

2.8.5.4. The Contractor shall ensure Provider payments are consistent with the provisions set forth in **Section 2.8.2**.

2.8.5.5. Non-Payment and Reporting

2.8.5.5.1. Non-Payment and Reporting of Serious Reportable Events

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

2.8.5.5.1.2. The Contractor shall notify EOHHS of SREs, in accordance with **Appendix A** and with guidelines issued by the Department of Public Health.

2.8.5.5.1.3. The Contractor shall provide, at a frequency and format specified by EOHHS a summary of SREs in accordance with Appendix A. Such summary shall include the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE.

2.8.5.5.2. Non-Payment and Reporting of Provider Preventable Conditions

2.8.5.5.2.1. The Contractor shall take such action as is necessary in order for EOHHS to comply with and implement all Federal and State laws, regulations, policy guidance, and MassHealth policies and procedures relating to the identification, reporting, and non-payment of provider

preventable conditions, including 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

2.8.5.5.2.2. In accordance with 42 CFR 438.3(g), the Contractor shall:

2.8.5.5.2.2.1. As a condition of payment, comply with the requirements mandating Provider identification of Provider-Preventable Conditions, as well as the prohibition against payment for Provider-Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26; and

2.8.5.5.2.2.2. Report all identified Provider-Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Appendix A**.

2.8.5.5.2.3. The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.3(g), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

2.8.5.5.2.3.1. The Contractor shall not pay a provider for a Provider Preventable Condition.

2.8.5.5.2.3.2. The Contractor shall require, as a condition of payment from the Contractor, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or EOHHS.

2.8.5.5.2.4. The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee.

2.8.5.5.2.5. A Contractor may limit reductions in provider payments to the extent that the following apply:

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

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

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

2.8.5.5.3. Non-Payment and Reporting of Preventable Hospital Readmissions

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

2.8.6. Critical Access Hospitals

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

2.8.7. Provider Directory

2.8.7.1. The Contractor shall maintain a searchable Provider directory (or directories) as further specified by EOHHS. Such directory (or directories) shall include PCPs, BH Providers, LTSS Providers, hospitals, specialists, sub-specialists, pharmacies, including a listing of statewide emergency rooms and Crisis Services providers, including CBHCs, that is made available in Prevalent Languages and Alternative Formats, upon request, and includes, at a minimum, the following information:

2.8.7.1.1. For PCPs, Behavioral Health Providers, LTSS Providers, hospitals, pharmacies, and specialists:

2.8.7.1.1.1. Alphabetical Provider list, including any specialty and group affiliation as appropriate;

2.8.7.1.1.2. Geographic list of Providers by town;

2.8.7.1.1.3. Office address and telephone numbers for each Provider, as well as website URL as appropriate;

2.8.7.1.1.4. Office hours for each Provider;

2.8.7.1.1.5. The Provider's Cultural and Linguistic Competence and capabilities, including languages spoken by Provider or by skilled medical interpreter at site, including ASL, and whether the Provider has completed cultural competence training;

2.8.7.1.1.6. Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment and other elements as directed by EOHHS, including in 130 CMR 438.010(h)(1)(viii);

2.8.7.1.1.7. PCPs with open and closed panels, where open panel refers to those accepting any new patient, and closed panel refers to those that are limited to the current patients only; and

2.8.7.1.1.8. Services offered via Telehealth.

2.8.7.1.2. For Behavioral Health Providers, required information also includes qualifications and licensing information, and special experience, skills, and training (i.e., trauma, geriatrics, LGBTQ+, substance use); and

2.8.7.1.3. For Long-Term Services and Supports Providers, required information also includes a list of all services provided by the organization or ASAP (i.e., Home Health, Adult Foster Care, Personal Care Management, etc.).

2.8.7.1.4. For pharmacies:

2.8.7.1.4.1. Alphabetical listing of the pharmacy chains included in the Contractor's network;

2.8.7.1.4.2. Alphabetical listing of independent pharmacies, including addresses and phone numbers; and

2.8.7.1.4.3. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient pharmacy.

2.8.7.1.5. For Dental Health:

2.8.7.1.5.1. Develop a current directory of all Dental Providers in Active Status. The directory of all Dental Providers in Active Status shall be available to Members via the Customer Web Portal and via EOHHS hosted website, and shall allow for multiple search capabilities as approved by EOHHS; and County-specific sections shall be made available in hard copy to Customers, upon request. The Contractor's online Dental Provider directory shall be populated against Contractor's online data systems. The Contractor shall ensure the Dental Provider directory includes, at a minimum, the following information:

2.8.7.1.5.1.1. Dental Provider's name;

2.8.7.1.5.1.2. Practice site address(es) including ZIP code and County;

2.8.7.1.5.1.3. Dental Provider's area(s) of specialty;

2.8.7.1.5.1.4. Age category of Members seen (adult only);

2.8.7.1.5.1.5. Dental practice status: open (accepting new Members) or closed (not accepting new Members);

2.8.7.1.5.1.6. Dental Provider's telephone number; and

2.8.7.1.5.1.7. Dental Provider's or practice's internet address, if applicable.

2.8.7.1.5.1.8. Dental Provider's office hours;

2.8.7.1.5.1.9. Languages spoken;

2.8.7.1.5.1.10. Whether or not the Dental Provider's office has accommodations for people with physical or cognitive disabilities, including offices, exam rooms, and equipment;

2.8.7.1.5.1.11. Whether the Dental Provider has any advanced training or experience in serving persons with physical or cognitive disabilities and, if applicable, a brief description of this training and/or experience; and

2.8.7.1.5.1.12. Any other practical information about the Dental Provider.

2.8.7.1.5.2. Update the Dental Provider directory at least monthly with any new information obtained through credentialing and re-

credentialing of Dental Providers, as detailed in this **Section 2.8.7.1.5**; outreach by Provider Relations Representatives or other outreach to Providers, as detailed in **Section 3.3**; secret shopper surveys, as detailed in **Section 2.10.7** and ; disenrollment notifications as detailed in **Section 2.4.12**; and information collected to develop the Dental Provider Network Administration Reports detailed in **Appendix P.**

2.8.7.2. The Contractor shall maintain accurate provider directory data. EOHHS may, at the sole discretion of EOHHS, conduct periodic audits within thirty (30) days of February 1, 2026, and annually thereafter, and within thirty (30) days of August 1, 2026, and annually thereafter, to verify the accuracy of Contractor's provider directory data. Contractor shall maintain an accuracy rate of at least 80% in regard to the listed status (i.e., Active or Inactive) of each Dental Provider.

2.8.7.3. The Contractor shall maintain complete provider directory data. EOHHS may, at the sole discretion of EOHHS, conduct periodic audits, within thirty (30) days of February 1, 2026, and annually thereafter, and within thirty (30) days of August 1, 2026, and annually thereafter, to verify the completeness of Contractor's provider directory data. Contractor shall ensure that no more than 20% of required information, as detailed in this **Section 2.8.7**, is missing.

2.8.7.4. The Contractor shall establish and sustain a publicly accessible, standards-based Provider directory application programming interface (API) in accordance with federal law, including but not limited to the Consolidated Appropriations Act, 2023 and the CMS Interoperability and Patient Access final rule.

2.9. Network Management

2.9.1. General Requirements

2.9.1.1. The Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services and quality. The management strategy shall:

2.9.1.1.1. Incorporate the principles of rehabilitation and recovery for Behavioral Health Services, Independent Living Principles, Cultural and Linguistic Competence, integration, and cost effectiveness;

2.9.1.1.2. Address all providers;

2.9.1.1.3. Include a system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

2.9.1.1.4. Include a system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals; and

2.9.1.1.5. Include conducting announced and unannounced on-site visits to Network providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements.

2.9.1.2. The Contractor shall:

2.9.1.2.1. Ensure the Provider Network provides adequate access to all Covered Services; and

2.9.1.2.2. Ensure that all providers are appropriately credentialed, maintain current licenses, are currently accepting and treating patients and have appropriate locations to provide the Covered Services.

2.9.1.2.3. Establish and conduct an ongoing process for enrolling in their Provider Network any willing and qualified provider that meets the Contractor's requirements and with whom mutually acceptable provider Contract terms, including with respect to rates, are reached.

2.9.1.2.4. Monitor and enforce access and other Network standards required by this Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance;

2.9.1.2.5. Demonstrate, through reports specified in **Appendix A**, that it satisfies the following requirements. The Contractor shall submit such reports at the frequency specified in **Appendix A** and no less frequent than at the time it executes this Contract, on an annual basis, and at any time there is a significant change, as defined by EOHHS, in the Contractor's operations that would affect the adequacy of capacity and services.

2.9.1.2.5.1. Offers an appropriate range of preventive/primary care and specialty services that is adequate for the anticipated number of Enrollees throughout the Contractor's Regions; and

2.9.1.2.5.2. Maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees throughout the Contractor's Regions as defined in **Section 2.9.2. below**;

2.9.1.2.6. Operate a toll-free telephone line for Provider inquiries during normal business hours for a minimum of eight (8) hours per day,

Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services provided, however, that the Contractor and its Providers shall not require such verification prior to providing Emergency Services.

2.9.1.2.7. Maintain and distribute a provider manual(s), which includes specific information about Covered Services, non-Covered Services, and other requirements of the Contract relevant to provider responsibilities. The Contractor shall submit an updated provider manual(s) to EOHHS annually and document all changes, or updates made to the provider manual(s). Such updated provider manual(s) shall be distributed to providers annually and made available to providers on the Contractor's website. The provider manual(s) shall include, but not be limited to, the following information/requirements:

2.9.1.2.7.1. Enrollee rights and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;

2.9.1.2.7.2. Provider responsibilities as a Member of the ICT;

2.9.1.2.7.3. That Enrollees may file a Grievance with the Contractor if the provider violates any Enrollee rights and the steps the Contractor may take to address any such Grievances;

2.9.1.2.7.4. Enrollee privacy matters;

2.9.1.2.7.5. That Providers shall make interpreter services available to Enrollees, providers shall not allow family members or other caregivers to serve as the interpreter except in instances of an emergency or if the provider will have to deny care, if the provider allows a family member or other caregiver to serve as the interpreter the provider shall document it in the record as well as the reason an interpreter was not available;

2.9.1.2.7.6. The Provider's obligation to accept and treat all Enrollees regardless of race/ethnicity, age, English proficiency, gender identity, sexual orientation, health status, or disability;

2.9.1.2.7.7. General rules of provider-Enrollee Communications;

2.9.1.2.7.8. Covered Services lists;

2.9.1.2.7.9. The Provider's obligation to make Enrollees aware of available clinical options and all available care options;

2.9.1.2.7.10. Permissible provider marketing activities;

2.9.1.2.7.11. That Providers may not charge Enrollees or the Contractor for any service that (a) is not a Medically Necessary Covered Service or non-covered service, (b) for which there may be other Covered Services or non-Covered Services that are available to meet the Enrollee's needs, and (c) where the provider did not explain items (a) and (b) , that the Enrollee will not be liable to pay the provider for the provision of any such services. The provider shall be required to document compliance with this provision;

2.9.1.2.7.12. Information on Advance Directives, as defined in 42 C.F.R. § 489.100, and pursuant to 42 C.F.R. § 422.128, 130 CMR 450.112, and 42 CFR 438.3(j);

2.9.1.2.7.13. The Contractor's authority to audit the presence of Advance Directives in medical records;

2.9.1.2.7.14. Services that need PCP referrals or prior authorization;

2.9.1.2.7.15. Full explanation of new Enrollee's right to the initial continuity-of-care period;

2.9.1.2.7.16. Enrollee rights to access and correct medical records information;

2.9.1.2.7.17. The process through which the Contractor communicates updates to policies (for providers and Material Subcontractors);

2.9.1.2.7.18. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

2.9.1.2.7.19. Protocols for transitioning Enrollees from one Behavioral Health Provider to another;

2.9.1.2.7.20. Protocols for communication and coordination between Members of the Enrollee's ICT, including access to electronic health records or care management portals;

2.9.1.2.7.21. Coordination between Behavioral Health Providers and PCPs;

2.9.1.2.7.22. Coordination between Behavioral Health Providers and State agencies, including but not limited to Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole, and AGE;

2.9.1.2.7.23. Steps a provider shall take to request disenrollment of an Enrollee from their panel;

2.9.1.2.7.24. Information on the Contractor's administrative Appeals process;

2.9.1.2.7.25. Information on the Contractor's process for an internal Appeal following an Adverse Action, including an Enrollee's right to use a provider as an Appeal representative; and

2.9.1.2.7.26. Information on the policy against balance billing.

2.9.1.2.8. Maintain a protocol that shall facilitate communication to and from providers and the Contractor;

2.9.1.2.9. Except when required by law or authorized by EOHHS, make best efforts to ensure that providers receive thirty (30) days advance notice in writing of policy and procedure changes and maintain a process to provide education and training for providers regarding any changes that may be implemented prior to the policy and procedure changes taking effect;

2.9.1.2.10. Work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Goals and all other requirements of this Contract; and

2.9.1.2.11. Collect data from providers in a standardized format to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts, consistent with 42 CFR 438.242(b)(3)(iii).

2.9.1.3. Responsiveness to Provider Requests to Enter into Agreement with the Contractor

2.9.1.3.1. The Contractor shall develop and maintain, and provide to EOHHS for review, policies and procedures regarding its responsiveness to provider requests to enter into agreements with the Contractor to provide services to an Enrollee, including but not limited to Provider Contracts and single case agreements. Such policies and procedures shall include, but may not be limited to, how the Contractor:

2.9.1.3.1.1. Acknowledges receipt of the request, including whether such acknowledgement is in writing or in another manner, and

2.9.1.3.1.2. Provides a reasonable estimate as to the time it will take for the Contractor to make a decision with respect to such

request, including whether such estimate takes into account the Enrollee's health condition.

2.9.2. Primary Care Provider Network

2.9.2.1. The Contractor shall report to EOHHS, in accordance with **Appendix A**, the following:

2.9.2.1.1. A geographic access report for PCPs demonstrating access by geography; and

2.9.2.1.2. A PCP-to-Enrollee ratio report showing open and closed PCPs per number of Enrollees.

2.9.2.2. The Contractor shall make best efforts to ensure that PCP turnover does not exceed seven (7%) percent annually. The Contractor shall monitor and annually report to EOHHS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's Plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds seven (7%) percent, the Contractor shall submit an explanation for the turnover rate to EOHHS. EOHHS may subsequently request a business plan addressing the turnover rate for EOHHS review and approval.

2.9.2.3. The Contractor shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long-term patient doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for any Behavioral Health Services may be indicated, including situations where the Contractor suspects drug seeking behavior.

2.9.2.4. The Contractor shall provide access to appropriate PCPs in accordance with **Section 2.8.7.1**. An appropriate PCP is defined as a PCP who:

2.9.2.4.1. Has qualifications and expertise commensurate with the health care needs of the Enrollee; and

2.9.2.4.2. Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner.

2.9.2.5. The Contractor shall provide access to PCPs with open panels in accordance with Section **2.10.4**.

2.9.3. Behavioral Health Network Requirements

2.9.3.1. Substance Use Disorder Treatment Providers

2.9.3.1.1. To the extent permitted by law, the Contractor shall require all substance use disorder treatment providers to submit to DPH/BSAS the data required by DPH.

2.9.3.1.2. The Contractor shall require all substance use disorder treatment providers to track, by referral source:

2.9.3.1.2.1. All referrals for services;

2.9.3.1.2.2. The outcome of each referral (i.e., admission, etc.); and

2.9.3.1.2.3. If the substance use disorder treatment provider refuses to accept a referral, the reason for the refusal.

2.9.3.2. The Contractor shall implement a unified Network Management strategy that ensures access to the continuum of care for Behavioral Health, consistent with the Behavioral Health requirements in **Section 2.7** and **2.8**. The network shall include, at a minimum, access to:

2.9.3.2.1. All Behavioral Health Services listed in **Appendix C**;

2.9.3.2.2. MassHealth Community Behavioral Health Centers (CBHCs) listed in **Appendix G Exhibit 1**;

2.9.3.2.3. State-Operated Community Mental Health Centers (SOCMHCs) listed in **Appendix G Exhibit 2**,

2.9.3.2.4. Hospitals Operated by DMH in **Appendix G Exhibit 4**; and

2.9.3.2.5. Covered Services in **Appendix C, Exhibit 2**.

2.9.3.3. The Contractor shall refer cases to the SOCMHCs in a manner that is consistent with the policies and procedures for Network referrals generally. See **Appendix G**, for a list of SOCMHCs, which may be updated by EOHHS from time to time.

2.9.3.4. The Contractor shall require Hospitals with DMH-licensed beds in its Provider Network to comply with the Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards that follow, as they appear in DMH Licensing Division Bulletin #19-01 (or any amended or successor bulletin), when delivering Inpatient Mental Health Services in those DMH-licensed beds to specialty populations.

2.9.3.5. The Contractor shall require all hospitals in its Provider Network, including those that do not have DMH-licensed beds, to have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed

within the hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with co-occurring Substance Use Disorders (SUD), Autism Spectrum Disorder and Intellectual and Developmental Disabilities (ASD/ID/DD), and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk.

2.9.3.6. The Contractor shall work collaboratively with EOHHS and EOHHS's BH Vendor to support the CBHC program, as further specified by EOHHS.

2.9.3.7. Community Support Program for Homeless Individuals (CSP-HI)

2.9.3.7.1. Subject to the Medical Necessity requirements set forth in 130 CMR 450.204 and **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements, and in at least the minimum amount, duration, and scope described in 130 CMR 461.403, under CSP-HI the Contractor shall provide CSP services as set forth in **Appendix C** to eligible Enrollees who meet the following criteria:

2.9.3.7.1.1. Homeless Enrollees who meet the definition of Chronically Homeless in **Section 1.31**; or

2.9.3.7.1.2. Homeless Enrollees who do not meet the Chronically Homeless definition but who are also high utilizers of MassHealth services as defined by MassHealth.

2.9.3.7.2. The Contractor shall:

2.9.3.7.2.1. Authorize, arrange, coordinate, and provide CSP-HI services as set forth in **Appendix C** to Enrollees who meet the criteria under this **Section 2.9.3.7**;

2.9.3.7.2.2. Actively communicate with CSP-HI providers regarding the provision of CSP-HI services to Enrollees, including coordinating care to ensure that Enrollees' needs are met;

2.9.3.7.2.3. Require that Network Providers of CSP-HI have demonstrated experience and employed staff as further specified by EOHHS and in 130 CMR 461.000 including Homelessness experience and expertise;

2.9.3.7.2.4. Develop Performance Specifications for the delivery of CSP-HI as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

2.9.3.7.2.5. Pay CSP-HI Providers a daily rate. Once the Enrollee has obtained housing, continue to pay CSP-HI Providers the daily rate until such a time as the Contractor determines that CSP-HI is no longer medically necessary;

2.9.3.7.2.6. Ensure that rates paid for CSP-HI services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

2.9.3.7.2.7. Designate a single point of contact for CSP-HI to provide information to CSP-HI providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contract designated for CSP-TPP as described in **Section 2.9.3.9**; and

2.9.3.7.2.8. Collect and maintain written documentation that the Enrollees receiving CSP-HI meet the definitions under **Section 2.9.3.7.1,** and as further specified by EOHHS.

2.9.3.8. Community Support Program for Justice Involvement (CSP-JI)

2.9.3.8.1. The Contractor shall ensure access to CSP-JI,

2.9.3.8.2. Subject to the Medical Necessity requirements under 130 CMR 450.204 and in **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements and in at least the minimum amount, duration, and scope described in 130 CMR 461.403,the Contractor shall provide CSP services as set forth in **Appendix C**, to individuals with Justice Involvement as described in this Section.

2.9.3.8.3. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix C**, to Enrollees with Justice Involvement that consist of intensive, and individualized support delivered face-to-face or via telehealth, as further specified by EOHHS, which shall include:

2.9.3.8.3.1. Assisting in enhancing daily living skills;

2.9.3.8.3.2. Providing service coordination and linkages;

2.9.3.8.3.3. Assisting with obtaining benefits, housing, and healthcare;

2.9.3.8.3.4. Developing a safety plan;

2.9.3.8.3.5. Providing prevention and intervention; and

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

2.9.3.8.4. The Contractor shall, as further directed by EOHHS, with respect to CSP-JI:

2.9.3.8.4.1. Actively communicate with CSP-JI providers regarding the provision of CSP-JI services, including coordinating care to ensure that individuals' needs are met,

2.9.3.8.4.2. Ensure that network providers of CSP-JI have demonstrated experience and engage in specialized training,

2.9.3.8.4.3. Report to EOHHS about its network providers of CSP-JI in accordance with **Appendix A**, and

2.9.3.8.4.4. Designate a single point of contact for CSP-JI to provide information to CSP-JI providers and EOHHS as further specified by EOHHS.

2.9.3.8.5. When directed by EOHHS, the Contractor shall maintain agreements with Behavioral Health Supports for individuals with Justice Involvement providers, as further specified by EOHHS.

2.9.3.9. Community Support Program Tenancy Preservation Program (CSP-TPP)

2.9.3.9.1. Subject to the Medical Necessity requirements under 130 CMR 450.204 and in **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements and in at least the minimum amount, duration, and scope described in 130 CMR 461.403,, the Contractor shall provide CSP-TPP services as set forth in **Appendix C** to Covered Individuals who are at risk of homelessness. For the purposes of this Section "at risk of homelessness" is defined as a Covered Individual who:

2.9.3.9.1.1. Does not have sufficient resources or support networks (e.g., family, friends, faith-based, or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation;

2.9.3.9.1.2. Is facing eviction, e.g., the process of obtaining a court order to remove a tenant and other occupants from a rental property including serving either a Notice to Quit or a request for temporary, preliminary, permanent relief. Eviction may also refer to any instance in which such relief has been granted.

2.9.3.9.2. The Contractor shall:

2.9.3.9.2.1. Authorize, arrange, coordinate, and provide CSP-TPP services as set forth in **Appendix C** to Covered Individuals who meet the criteria under **Section 2.9.3.9**;

2.9.3.9.2.2. Actively communicate with CSP-TPP providers regarding the provision of CSP-TPP services to Covered Individuals, including coordinating care to ensure that Covered Individuals' needs are met;

2.9.3.9.2.3. Require the Network Providers of CSP-TPP have demonstrated experience and employed staff as further specified by EOHHS and in 130 CMR 461.000;

2.9.3.9.2.4. Develop Performance Specifications for the delivery of CSP-TPP as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

2.9.3.9.2.5. Pay CSP-TPP Providers a daily rate and continue to pay CSP-TPP Providers the daily rate until such a time as the Contractor determines that CSP-TPP is no longer medically necessary;

2.9.3.9.2.6. Ensure that rates paid for CSP-TPP services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

2.9.3.9.2.7. Designate a single point of contact for CSP-TPP to provide information to CSP-TPP providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contact designated for CSP-HI as described in **Section 2.9.3.7**; and

2.9.3.9.2.8. Collect and maintain written documentation that the Enrollees receiving CSP-TPP meet the definitions under **Section 2.9.3.9** as further specified by EOHHS.

2.9.3.10. The Contractor shall incorporate DMH's Infection Control Competencies/Standards, as set forth in Attachments A and B to DMH Licensing Bulletin 20-05R, or successor guidance, in its contracts with DMH-licensed providers of Inpatient Mental Health Services. The Contractor shall review such facility's compliance with the applicable DMH requirements as part of the Contractor's program integrity efforts pursuant to **Section 2.3.6**. The Contractor shall promptly report any

noncompliance with the applicable DMH standards to EOHHS and shall treat such noncompliance in accordance with the Contractor's program integrity activities pursuant to **Section 2.3.6**.

2.9.4. Long-Term Services and Supports Provider Network

2.9.4.1. General

2.9.4.1.1. The Contractor's Provider Network shall offer a selection of nursing facility and community LTSS providers that meets Enrollee needs and preferences and satisfies the time and distance requirements at **Section 2.10.4**.

2.9.4.1.2. The Contractor shall maintain a network that ensures timely discharge from the hospital and admission to a nursing facility for enrollees when an admission to a nursing facility is medically necessary because the enrollee cannot be safely supported in the community.

2.9.4.2. Personal Care Network

2.9.4.2.1. The SCO Plan Contractor shall meet Personal Care Network requirements, including for intake and orientation, skills training, development of Service Agreements, and assessment of the Enrollee's ability to manage Self-directed PCA Services independently.

2.9.4.2.2. The Contractor shall contract with Personal Care Management (PCM) Agencies that are under contract with EOHHS to provide PCM Services to Enrollees accessing Self-directed PCA Services.

2.9.4.2.3. Enrollees who are authorized to receive Self-directed PCA Services at the time of enrollment with the Contractor shall be granted the option of continuing to receive their PCM Services through their current PCM provider, to ensure continuity of Self-directed PCA Services.

2.9.4.2.4. Enrollees who are not authorized to receive Self-directed PCA Services at the time of enrollment shall be offered a choice of at least two PCM Agencies. Enrollees shall be offered the option of receiving PCM Services through an Aging Services Access Point (ASAP) operating as a PCM.

2.9.4.3. PCA Services Evaluations

2.9.4.3.1. The Contractor shall ensure that PCA evaluations are done in a timely manner to ensure appropriateness and continuity of services.

2.9.4.3.2. The Contractor shall contract with PCM Agencies under contract with EOHHS to perform evaluations for PCA services.

2.9.4.4. Promoting Self-Direction of Services

2.9.4.4.1. The Contractor shall provide education, choice, and needed supports to promote self-direction of PCA by Enrollees. The Contractor shall inform Enrollees that they may identify a surrogate to help them if they choose Self-directed PCA Services.

2.9.4.4.2. The Contractor shall pay for services rendered by the PCA hired by the Enrollee if the PCA meets MassHealth requirements in 130 CMR 422.411 (A)(1) and has completed the required Fiscal Intermediary paperwork. The Contractor shall pay the Fiscal Intermediary the PCA rate as set by EOHHS under 101 CMR 309.00, which includes both the PCA collective bargaining wage, payment for employer required taxes, and workers' compensation insurance.

2.9.4.4.3. The Contractor shall contract with the Fiscal Intermediary under contract with EOHHS to support Enrollees in fulfilling their employer required obligations related to the payment of PCAs.

2.9.4.5. Agency Personal Care for Enrollees who do not choose Self-directed PCA

2.9.4.5.1. The Contractor shall provide Enrollees who do not choose Self-directed PCA, or who are not able to find a surrogate to assist them to self-direct, with the option of having their personal care provided by an agency.

2.9.4.5.2. The Contractor shall contract with such agencies and provide Enrollees with the choice of at least two personal care agency providers, except that with EOHHS prior approval, Contractor may offer Enrollees only one personal care agency provider. Services provided by personal care agency providers shall be person-centered and the Enrollee shall have a choice of the schedule for PCAs and of who provides personal care.

2.9.4.6. For Enrollees receiving PCA services that are disenrolling from the Contractor, the Contractor shall include provisions in its contracts with PCM agencies requiring compliance with EOHHS's continuity of PCA services procedures (see **Section 2.6.5**).

2.9.4.7. Personal Assistance Overtime

2.9.4.7.1. The Contractor shall 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). The Contractor shall require such PCM Agency to agree to:

2.9.4.7.1.1. Attend trainings as directed by EOHHS,

2.9.4.7.1.2. Comply with reporting requirements for PCA services as directed by EOHHS,

2.9.4.7.1.3. Respond to Enrollee inquiries regarding overtime management and overtime approval requests,

2.9.4.7.1.4. Educate Enrollees that do or may need to schedule PCAs for more than fifty (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),

2.9.4.7.1.5. Assist Enrollees that do or may need to schedule PCAs to work more than fifty (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,

2.9.4.7.1.6. 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,

2.9.4.7.1.7. 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,

2.9.4.7.1.8. Communicate MassHealth's decisions regarding overtime approval requests within one business day to Enrollees and to the Contractor,

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

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

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

2.9.4.7.1.9.3. 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

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

2.9.4.7.1.10. Receive and maintain lists provided by the Fiscal Intermediary that identify Enrollees who employ PCAs that work more than fifty (50) hours per week; and

2.9.4.7.1.11. Prioritize the list of existing Enrollees who employ PCAs that work more than fifty (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.

2.9.4.7.2. 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:

2.9.4.7.2.1. The number of overtime approval requests received; and

2.9.4.7.2.2. The number of overtime approval requests submitted to MassHealth.

2.9.4.8. Responsibilities Related to PCAs Employed by the Contractor's Enrollees

2.9.4.8.1. The Contractor shall implement a mechanism for receiving, investigating, and responding to Grievances, whether formal or informal, alleging non-payment of wages owed to PCAs employed by one or more of the Contractor's Enrollees.

2.9.4.8.2. 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 Grievance 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 Grievance 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:

2.9.4.8.2.1. The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim; and

2.9.4.8.2.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

2.9.5. Sexual and Reproductive Health/Family Planning Provider Network

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

2.9.5.1.1. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services,

2.9.5.1.2. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the SCO Plan network,

2.9.5.1.3. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:

2.9.5.1.3.1. All methods of contraception, including sterilization, vasectomy, and emergency contraception;

2.9.5.1.3.2. Counseling regarding HIV, pre-exposure prophylaxis (PrEP) for HIV, post-exposure prophylaxis (PEP) for HIV, sexually transmitted diseases, including vaccinations to prevent sexually transmitted diseases, and risk reduction practices; and

2.9.5.1.3.3. Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, and pregnancy termination.

2.9.5.1.4. Maintain sufficient family planning Providers to ensure timely access to family planning services.

2.9.5.1.5. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.

2.9.6. Reserved

2.9.7. Dental Provider Network

2.9.7.1. The Contractor shall, by August 31, 2025, and annually thereafter, contact all offices that treated Members with disabilities, including IDD, during the previous Contract Year, determine each of those offices' capacity to treat Enrollees with disabilities, including IDD, and encourage each of those offices to treat additional Enrollees by providing training on how best to treat Enrollees with disabilities, including IDD.

2.9.7.2. The Contractor shall create and submit to EOHHS for approval a Member Care Access Plan to expand Network capacity for Enrollees with disabilities, including IDD. This plan shall include, at minimum:

2.9.7.2.1. Meeting monthly with a representative from a Provider group, to be designated by EOHHS, that specializes in treatment for Enrollees with disabilities, including IDD.

2.9.7.2.2. The goal of these monthly meetings shall be to identify opportunities to connect Enrollees to dental care and to create Network capacity for Enrollees with disabilities, including IDD individuals.

2.9.7.2.3. The Contractor shall document these efforts and update its provider directory.

2.9.7.2.4. The Contractor shall ensure that Enrollee Services will have a referral list to utilize if an Enrollee should need placement.

2.9.7.3. The Contractor shall make best efforts to contract with Mobile Providers. The Contractor shall outreach to any non-network Mobile Providers at least annually to attempt to contract with them.

2.9.8. Provider Credentialing, Screening, and Board Certification

2.9.8.1. General Provider Credentialing

2.9.8.1.1. The Contractor shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§ 422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention, and exclusion of providers and meet, at a minimum, the requirements below.

2.9.8.1.2. The Contractor shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually that all providers within the Contractor's Provider Network are credentialed according to such policies and procedures. The Contractor shall:

2.9.8.1.2.1. Designate a person/ people at the Contractor's organization who are responsible for provider credentialing and re-credentialing;

2.9.8.1.2.2. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers (e.g., RNs, PAs, and LICSWs) 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 must also be consistent with any uniform credentialing policies specified by EOHHS addressing acute, primary, and Behavioral Health Providers, including but not limited to substance use disorder providers, and any other EOHHS-specified providers;

2.9.8.1.2.3. 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 such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations;

2.9.8.1.2.4. Maintain a documented re-credentialing process that:

2.9.8.1.2.4.1. Shall occur at least every three (3) years (thirty-six months) and shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews, utilization management information, and Enrollee satisfaction surveys;

2.9.8.1.2.4.2. 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 must also be consistent with any uniform re-credentialing policies specified by EOHHS addressing acute, primary, and Behavioral Health Providers, including but not limited to substance use disorder providers, and any other EOHHS-specified providers; and

2.9.8.1.2.4.3. The Contractor shall, 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.

2.9.8.2. Provider Screening and Monitoring

2.9.8.2.1. The Contractor shall monitor providers and prospective providers by monitoring all of the databases described in **Appendix I**, at the frequency described in **Appendix I** as follows:

2.9.8.2.1.1. The Contractor shall search the databases in **Appendix I** 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.

2.9.8.2.1.2. 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 I**.

2.9.8.2.2. The Contractor shall identify the appropriate individuals to search and evaluate pursuant to this **Section 2.9.8.2** by using, at a minimum, the Federally Required Disclosures Form provided by EOHHS.

2.9.8.2.3. The Contractor shall submit a monthly Excluded provider Monitoring Report to EOHHS, as described in **Appendix A**, which demonstrates the Contractor's compliance with this **Section 2.9.8.2**. At the request of EOHHS, the Contractor shall provide additional information demonstrating to EOHHS's 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 I**.

2.9.8.2.4. The Contractor shall develop and maintain policies and procedures to implement the requirements as set forth in this **Section 2.9.8.2** and to comply with 42 C.F.R. § 438.608(a)(1).

2.9.8.2.5. 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 Provider Network as appropriate.

2.9.8.2.6. The Contractor shall notify EOHHS, through its Contract Manager, when it terminates, suspends, or declines a provider from its Provider Network because of fraud, integrity, or quality;

2.9.8.2.7. Consistent with 42 C.F.R. §438.608(d), the Contractor shall develop and maintain policies and procedures that support a process for the recoupment of overpayments to providers including those providers identified as excluded by appearing on any exclusion or debarment database including those at **Appendix I**. 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 including outreach to the Provider, voiding claims, and establishing a recoupment account; and

2.9.8.2.8. On an annual basis, the Contractor shall submit to EOHHS a certification checklist that it has implemented the actions necessary to comply with this **Section 2.9.8.2**.

2.9.8.2.9. This **Section 2.9.8.2** does not preclude the Contractor from suspending or terminating providers for cause prior to the ultimate suspension and termination from participation in MassHealth, Medicare, or another state's Medicaid program.

2.9.8.2.10. The Contractor shall not employ or contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished, directed or prescribed under the plan by any individual or entity during any period when the individual or entity has been excluded from participation under title V, XVIII, XIX, or XX, or Sections 1128, 1128A, or 1842(j) of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and 1001.1901, furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person), furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments, and furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.2.

2.9.8.2.10.1. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under Section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

2.9.8.2.11. The Contractor shall not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.9.8.2.12. The Contractor shall ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other State or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90.

2.9.8.2.13. The Contractor shall search for the names of and not contract with parties disclosed during the credentialing process in the databases in **Appendix I** in accordance with the Contractor's obligations set forth in **Section 2.9** and the MassHealth exclusion list, and parties that have been terminated from participation under Medicare or another state's Medicaid program.

2.9.8.2.14. The Contractor shall obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. 1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to EOHHS in accordance with this Contract, including this **Section 2.9** and relevant State and federal laws and regulations; and

2.9.8.2.15. The Contractor shall notify EOHHS when a provider fails credentialing or re-credentialing because of a program integrity reason and shall provide related and relevant information to EOHHS as required by EOHHS or State or federal laws, rules, or regulations.

2.9.8.3. Board Certification Requirements

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

2.9.8.3.1.1. Require that all applicant physicians be board certified in their practicing medical specialty, or are in the process of achieving initial certification as a condition for participation, except as otherwise set forth in below:

2.9.8.3.1.1.1. Except as otherwise set forth below, require that all participating physicians achieve board certification in a time frame relevant to the guidelines established by their respective medical specialty boards, as applicable;

2.9.8.3.1.1.2. If necessary to ensure adequate access, the Contractor may contract with providers who have training consistent with board eligibility but are not board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address; and

2.9.8.3.1.1.3. Provide a mechanism to monitor participating physician compliance with the Contractor's board certification requirements, including, but not limited to, participating physicians who do not achieve board certification within the applicable time frames.

2.9.8.4. Behavioral Health Provider Credentialing

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

2.9.8.4.1.1. Implement the Behavioral Health Credentialing Criteria as prior approved by EOHHS;

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

2.9.8.4.1.3. For Behavioral Health Providers treating substance use disorders, the Contractor shall require these providers to report to it on CEU trainings they have participated in on substance use disorder;

2.9.8.4.1.4. For a Behavioral Health Services Provider that is a hospital that provides Behavioral Health Inpatient Services, the Contractor shall ensure that such hospital has a human

rights protocol that is consistent with the Department of Mental Health requirements to this Contract and includes training of the Behavioral Health Provider's staff and education for Enrollees regarding human rights; and

2.9.8.4.1.5. For a Behavioral Health Services Provider that is a hospital that provides Behavioral Health Inpatient Services, the Contractor shall 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.

2.9.8.5. Frail Elder Waiver Provider Credentialing and Monitoring

2.9.8.5.1. In addition to the provider credentialing and qualification requirements set forth in this Contract, the Contractor shall ensure that, for all providers who provide waiver services to FEW Enrollees, such providers meet the provider qualification, certifications, and other requirements set forth in Appendices C-1 and C-3 of the Frail Elder Waiver (**Appendix S**).

2.9.8.5.2. As provided in Appendix H of the Frail Elder Waiver (see **Appendix S**), the Contractor shall complete onsite audits at least once during the first six months after initial services are delivered, and thereafter once every 2-3 years, depending on provider type, to ensure compliance.

2.9.8.5.3. In the event that such services are purchased or arranged through a Material Subcontractor, such credentialing and qualification requirements apply to and shall be assessed for individual providers.

2.9.8.6. Contracts with ASAPs for GSSCs

2.9.8.6.1. GSSCs shall meet the standard established by the AGE in designating ASAPs as qualified to serve as GSSCs

2.9.8.6.2. The Contractor's agreement with ASAPs for the provision of GSSCs shall meet all requirements of a Material Subcontractor contract and relationship

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

2.9.9. Provider Profiling

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

2.9.9.2. Provider profiling activities shall include, but are not limited to:

2.9.9.2.1. Developing Provider specific reports that include a multidimensional assessment of a provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

2.9.9.2.2. Establishing provider, group, or regional benchmarks for areas profiled, where applicable, including Contractor specific benchmarks, if any;

2.9.9.2.3. Providing feedback to providers regarding the results of their performance and the overall performance of the Provider Network; and

2.9.9.2.4. Designing and implementing quality improvement plans for providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests, including referral of these providers to the Network Management staff for education and technical assistance and reporting results annually to EOHHS.

2.9.9.3. The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers. The Contractor shall:

2.9.9.3.1. Establish Provider specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals;

2.9.9.3.2. Develop and implement incentives, which may include financial and nonfinancial incentives, to motivate Providers to improve performance on profiled measures;

2.9.9.3.3. Conduct onsite visits to Network Providers for quality improvement purposes; and

2.9.9.3.4. At least annually, measure progress on the Provider Network and individual providers' progress, or lack of progress, towards meeting such improvement goals.

2.9.9.4. The Contractor shall maintain regular, systematic reports, in a form and format approved by EOHHS, of the abovementioned Provider profiling activities and related Quality Improvement activities pursuant to **Section 2.14.3**. Moreover, the Contractor shall submit to EOHHS, upon request, such reports or information that would be contained therein. The Contractor shall also submit summary results of such provider profiling and related Quality Improvement activities as a component of its annual evaluation of the QM/QI program.

2.9.10. Provider Education and Training

2.9.10.1. General

2.9.10.1.1. The Contractor shall:

2.9.10.1.1.1. Inform its Provider Network about its Covered Services and service delivery model;

2.9.10.1.1.2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;

2.9.10.1.1.3. Provide information about Grievances and Appeals policies, including about procedures and timeframes, to all providers and Material Subcontractors, per 42 C.F.R. § 438.414;

2.9.10.1.1.4. Inform its Provider Network about its quality improvement efforts and the Providers' role in such a program;

2.9.10.1.1.5. Inform its Provider Network about its policies and procedures, especially regarding in and non-network referrals, and ADA compliance, accessibility, and accommodations requirements, including as described in **Section 2.10.1.1.4**;

2.9.10.1.1.6. Develop and provide education to its Provider Network on Enrollee engagement roles, Utilization Management or Service Authorization roles, the availability and range of services, including behavioral health, community-based services, oral health, and LTSS services, available to meet Enrollee needs and the process for making Service Requests;

2.9.10.1.1.7. How providers access and collaborate with care coordination staff, including by leveraging the Centralized Enrollee Record;

2.9.10.1.1.8. Identification and treatment of incontinence;

2.9.10.1.1.9. Preventing falls;

2.9.10.1.1.10. Identification of and mandatory reporting requirements for abuse, neglect, and exploitation of elderly individuals;

2.9.10.1.1.11. The requirements of this contract related to continuity of care; and

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

2.9.10.2. Quality Improvement Education and Training

2.9.10.2.1. In collaboration with, and as further directed by EOHHS, the Contractor shall develop and implement quality improvement activities directed at:

2.9.10.2.1.1. Ensuring LTSS needs and goals are assessed, identified, and appropriately integrated with the other services provided and goals listed in the ICP; and

2.9.10.2.1.2. With respect to behavioral health screening, the Contractor shall develop and distribute Provider communications that shall give Providers information that describes:

2.9.10.2.1.2.1. The standardized behavioral health screening tools approved by EOHHS;

2.9.10.2.1.2.2. The Behavioral Health Services which are available when Medically Necessary including, but not limited to, Diversionary Services currently available and how Enrollees can access those services;

2.9.10.2.1.2.3. How and where to make referrals for follow up behavioral health clinical and LTSS assessments and services if such referrals are necessary in the judgment of the PCP;

2.9.10.2.1.2.4. Assisting EOHHS to improve tracking of delivered screenings, positive screenings and utilization of services by PCPs or Behavioral Health Providers following a behavioral health screening;

2.9.10.2.1.2.5. Improving ICT function and impact, particularly integration between primary care and behavioral health; and

2.9.10.2.1.2.6. Promoting the development of primary care practices that operate with the capabilities of a patient-centered medical home or health home.

2.9.10.3. Continuing Education

2.9.10.3.1. The Contractor shall provide education and training for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify behavioral health service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate.

2.9.10.3.2. The Contractor shall provide education and training as needed for all PCPs to familiarize PCPs with the principles of disability competent care, and to improve care, access and accommodations for persons with disabilities.

2.9.10.3.3. EOHHS may provide learning collaboratives for Contractor staff and providers, which may include webinars, online courses, in-person sessions and other activities.

2.9.11. CBHC Incentive Program

2.9.11.1. The Contractor shall:

2.9.11.1.1. Collaborate with CBHCs and EOHHS to implement the CBHC Incentive Program; and

2.9.11.2. Make value-based payments, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to such CBHCs.

2.10. Enrollee Access to Services

2.10.1. General

2.10.1.1. The Contractor shall provide services to Enrollees as follows:

2.10.1.1.1. Authorize, arrange, coordinate and provide to Enrollees all Medically Necessary Covered Services as specified in **Section 2.7.2** and **Appendix C**, in accordance with the requirements of the Contract.

2.10.1.1.2. Offer and ensure adequate choice, accessibility, and availability to Covered Services for all Enrollees, and to primary, specialty, acute

care, behavioral health, Long-term Services and Support, and oral health providers that meet EOHHS standards as provided in **Section 2.7**.

2.10.1.1.3. All such services shall be obtainable and available to Enrollees in a timely manner.

2.10.1.1.3.1. Obtainability shall be defined as the extent to which the Enrollee is able to receive services at the time they are needed. Receiving service refers to both telephone, video, or other real-time access and ease of scheduling an appointment.

2.10.1.1.3.2. Availability shall be defined as the extent to which the Contractor geographically distributes practitioners of the appropriate type and number to meet the needs of its Enrollees.

2.10.1.1.4. Reasonably accommodate persons and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities (including an individual with diverse linguistic and Cultural Competence needs) as they are to an individual without disabilities. The Contractor and its Material Subcontractors shall comply with all State and federal laws and regulations governing accessibility and accommodations, including the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), Massachusetts Public Accommodations Law (M.G.L. c. 272 s. 92A, 98, and 98A), and regulations promulgated by the Massachusetts Architectural Access Board at 521 CMR 1.00 et seq. The Contractor shall maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees; and

2.10.1.1.5. Ensure access to Covered Services in accordance with State and federal laws for persons with disabilities by ensuring that Network Providers are aware of and comply with such laws so that physical and communication barriers do not inhibit Enrollees from obtaining services under the Contract.

2.10.2. Timely Access (Obtainability)

2.10.2.1. The Contractor’s Provider Network shall ensure, through its Provider Network, that Enrollees have access to and can get Covered services as described in this **Section 2.10.2**.

2.10.2.2. Emergency Services

2.10.2.2.1. Immediately upon Enrollee presentation at the service delivery site, including non-network and out-of-area facilities;

2.10.2.2.2. In accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, coverage for Emergency Services to Enrollees twenty-four (24) hours a day and seven (7) days a week without regard to prior authorization or the Emergency Service Provider's contractual relationship with the Contractor;

2.10.2.2.3. Adult Mobile Crisis Intervention shall be available within 60 minutes of the time of the Enrollee's readiness to receive such an assessment.

2.10.2.3. Primary Care, Urgent Care, and Specialty Care

2.10.2.3.1. Primary Care shall be available:

2.10.2.3.1.1. Within forty-eight (48) hours of the Enrollee's request for Urgent Care;

2.10.2.3.1.2. Within ten (10) calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

2.10.2.3.1.3. Within forty-five (45) calendar days of the Enrollee's request for Non-Symptomatic Care.

2.10.2.3.1.4. Primary Care or Urgent Care shall be available during extended hours to reduce avoidable inpatient admissions and emergency department visits, as further specified by EOHHS.

2.10.2.3.2. Specialty care shall be available:

2.10.2.3.3. Within forty-eight (48) hours of the Enrollee's request for Urgent Care;

2.10.2.3.4. Within thirty (30) calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

2.10.2.3.5. Within sixty (60) calendar days for Non-Symptomatic Care.

2.10.2.4. Behavioral Health Services

2.10.2.4.1. Services shall be available within the following timeframes to Enrollees for Behavioral Health Services other than emergency services (as described above), or Mobile Crisis Intervention Services:

2.10.2.4.1.1. Urgent Care shall be available within 48 hours for services that are not Emergency Services or routine services.

2.10.2.4.1.2. All other Behavioral Health Services: within fourteen (14) calendar days.

2.10.2.4.1.3. For services described in the inpatient or twenty-four (24) Hour Diversionary Services Discharge Plan:

2.10.2.4.1.4. Non-twenty-four (24) Hour Diversionary Services – within two (2) calendar days of discharge;

2.10.2.4.1.5. Medication Management, including to review and refill medications – within fourteen (14) calendar days of discharge; and

2.10.2.4.1.6. Other outpatient services – within seven (7) calendar days of discharge.

2.10.2.5. Long-term Services and Supports (LTSS)

2.10.2.5.1. The Contractor's Provider Network shall ensure a selection of providers of community-based LTSS and nursing facilities that meets Enrollees' needs and preferences and satisfies the proximity requirements of this Contract.

2.10.2.5.2. If admission to a nursing facility is medically necessary because an Enrollee cannot be safely supported in the community, the Enrollee shall be admitted to a nursing facility within five (5) business days from the date the Enrollee is eligible to be discharged from a hospital.

2.10.3. Availability

2.10.3.1. The Contractor shall execute and maintain written contracts with Providers to ensure that Enrollees have access to Covered Services within a reasonable distance and travel time from the Enrollee's residence, as provided in **Section 2.10.4**. In determining compliance with this section and **Section 2.10.4**, the Contractor shall take into account only Providers meeting the requirements of Section **2.10.2**.

2.10.3.2. Primary Care Providers

2.10.3.2.1. The Contractor shall develop and maintain a network of Primary Care Providers that ensures PCP coverage and availability throughout its Service Area twenty-four (24) hours a day, seven (7) days a week.

2.10.3.2.2. The Contractor shall include in its Network and provide access to a sufficient number of appropriate PCPs to meet time and distance

requirements set forth in **Section 2.10.4 and Section 2.9.2**. An appropriate PCP is defined as a PCP who:

2.10.3.2.2.1. Is open at least twenty (20) hours per week;

2.10.3.2.2.2. Has qualifications and expertise commensurate with the health care needs of the Enrollee; and

2.10.3.2.2.3. Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner.

2.10.3.2.3. The Contractor shall provide access to PCPs with open panels in accordance with **Section 2.4.13**.

2.10.3.2.4. The Contractor shall promptly notify EOHHS of any County in its Service Area about which it has near-future concerns, or in which it sees upcoming obstacles in meeting the time and distance requirements for any County, including Network Adequacy requirements established by CMS for Medicare.

2.10.3.3. Other Physical Health Specialty Providers

2.10.3.3.1. The Contractor shall include in its Network and provide access to a sufficient number of specialty Providers to meet time and distance requirements set forth in accordance with **Section 2.10.2 and 2.10.4**.

2.10.3.4. Behavioral Health Services (as listed in **Appendix C**)

2.10.3.4.1. The Contractor shall include in its Network and provide access to a sufficient number of Behavioral Health Providers to meet time and distance requirements in accordance with **Section 2.10.2 and 2.10.4**.

2.10.3.4.2. In addition to these standards, the Contractor shall include in its Network the Providers set forth in **Appendix G, Exhibit 1** as indicated in **Section 2.8**.

2.10.4. Proximity Access Requirements

2.10.4.1. For Medicare pharmacy providers, the Contractor shall adhere to the time, distance and minimum number as required in 42 C.F.R. §423.120; and

2.10.4.2. For all non-pharmacy providers, the Contractor shall demonstrate annually that its Provider Network meets the stricter of the following standards, as applicable:

2.10.4.2.1. Adhere to CMS's most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor's service area; and

2.10.4.2.2. EOHHS standards specified below:

2.10.4.2.2.1. Enrollees shall have a choice of at least two (2) PCPs within the applicable time and distance standards;

2.10.4.2.2.2. Enrollees shall have a choice of two (2) hospitals within the applicable Medicare Advantage time and distance standards, except that if only one (1) hospital is located within a County, the second hospital may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence; and

2.10.4.2.2.3. Enrollees shall have a choice of two (2) nursing facilities within the applicable Medicare Advantage time and distance standards, except that if only one (1) nursing facility is located within a County, the second nursing facility may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence.

2.10.4.2.2.4. The Contractor shall demonstrate annually that its Provider Network has sufficient providers per Covered Service as referenced in **Section 2.7** and defined in **Appendix C** to ensure that each Enrollee has:

2.10.4.2.2.4.1. For outpatient and diversionary Behavioral Health Services, a choice of at least two (2) Providers that are either within a fifteen (15) mile radius or thirty (30) minutes from the Enrollee's ZIP code of residence;

2.10.4.2.2.4.2. For the following Covered Services, a choice of at least two Providers that will deliver services at the Enrollee's residence: Adult Foster Care, Durable Medical Equipment and Medical/Surgical Supplies, Oxygen and Respiratory Therapy Equipment, Home Health, Continuous Skilled Nursing, and other Frail Elder Waiver Services as described in **Appendix S**; and

2.10.4.2.2.4.3. For all other LTSS delivered in the community, a choice of at least two (2) Providers per Covered Service that are either within a fifteen (15) mile radius or thirty (30) minutes from the Enrollee's ZIP code of residence, except that with EOHHS prior approval, the Contractor may offer Enrollees only one community LTSS provider per Covered Service.

2.10.4.2.2.5. The Contractor shall demonstrate annually that its Provider Network includes sufficient providers to ensure that each Enrollee has access to one or more Anesthesiologists, Audiologists, Emergency Medicine Providers, Hematologists, Oral Surgeons, and Urgent Care centers, that are either within a twenty (20) mile radius or forty (40) minutes from the Enrollee's Zip code of residence.

2.10.4.2.2.6. The Contractor shall demonstrate annually that its Provider Network includes sufficient providers to ensure that each Enrollee has access to a choice of at least two (2) chronic disease and rehabilitation hospitals, at least one (1) of which is either within a thirty (30) mile radius or sixty (60) minutes from the Enrollee's Zip code of residence.

2.10.4.2.2.7. At least 90% of Enrollees in each of the Contractor's Service Areas shall have access to Providers in accordance with the time and distance standards in **Section 2.10.4**. If no time or distance is indicated, the Contractor shall have at least two (2) Providers located anywhere in the Commonwealth.

2.10.4.2.3. EOHHS reserves the right to update these standards; and

2.10.4.2.4. In determining compliance with the time and distance standards, the Contractor shall take into account only:

2.10.4.2.4.1. Providers with open panels (i.e., accepting new patients);

2.10.4.2.4.2. Providers serving current SCO Enrollees that would be in the Contractor's SCO Plan Network for the applicable coverage period, such Enrollees do not need additional open panel capacity for the particular service or provider type being evaluated for such Enrollees; and

2.10.4.2.5. The Contractor shall report to EOHHS annually in accordance with **Appendix A**, the following:

2.10.4.2.5.1. A specialist-to-Enrollee ratio report showing the number of each specialist by specialty type per the number of Enrollees;

2.10.4.2.5.2. As specified by EOHHS, a geographic access report for high volume specialty provider types based on utilization, demonstrating access by geography as specified in **Appendix A**; and

2.10.4.2.5.3. The time between the day an enrollee is eligible to be discharged from a hospital to the day the enrollee is admitted to a nursing facility.

2.10.4.2.6. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with 42 C.F.R. § 438.207(d). Such information shall include a certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding network adequacy, as well as any supporting documentation specified by EOHHS.

2.10.4.2.7. The Contractor shall have mechanisms in place to ensure compliance with timely access requirements pursuant to 42 C.F.R § 438.206 and **Section 2.10.2** of this Contract, including monitoring providers regularly to ensure compliance and taking corrective action if there has been a failure to comply.

2.10.4.3. Dental Access

2.10.4.3.1. The Contractor shall meet the Access Standards (as defined below), Travel Times (as defined below), Appointment Accessibility Standards (as defined below), and Wait Times (as defined below) for general, orthodontic and oral surgery practitioners by the Contract Implementation Date and thereafter throughout the life of the Contract except as described below;

2.10.4.3.1.1. Oral surgeons for Members residing in Barnstable, Berkshire, Dukes, Franklin, Hampden, Hampshire counties, and on Nantucket Island; and

2.10.4.3.1.2. General practitioners for Members residing in Barnstable, Berkshire, Dukes, Franklin, Hampden, and Hampshire counties, and on Nantucket Island;

2.10.4.3.2. In addition, the Contractor shall maintain, throughout the life of the Contract, an average over each Contract Year of at least 99% of the total number of Access Points (as defined in Appendix P) that exist as of the Contract Operational Start Date.

2.10.4.3.3. The Contractor shall monitor its compliance with these requirements and shall provide annual reports to EOHHS not later than 60 days after the end of each Contract Year regarding its compliance with these requirements (or otherwise upon EOHHS request), and shall promptly notify EOHHS at any point when there are fewer than 99% of Current Access Points for any of the specified provider types, or the provider to Member ratio or percentage of Members with access, or the

percentage of Members with access to care within Wait Time maximums fall below the specified ratio or percentage for any of the specified provider types.

2.10.4.3.4. The Contractor may request an exception to the above Current Access Points standard to account for pediatric-only dental providers in a County; any such exception request shall provide documentation of the pediatric-only dental providers included in the denominator (total number of Access Points existing at the Contract Operational Start Date); EOHHS may resolve the exception request by requiring the Contractor maintain an average access standard no lower than 95%.

2.10.5. Cultural and Linguistic Access

2.10.5.1. The Contractor shall have the capacity to meet the needs of the various linguistic groups in its Service Area. The following shall be available:

2.10.5.1.1. Multilingual Providers: The provision of care, including twenty-four (24) hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

2.10.5.1.1.1. Trained to translate in a medical setting;

2.10.5.1.1.2. Fluent in English;

2.10.5.1.1.3. Fluent in the Enrollee's language; and

2.10.5.1.1.4. Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS.

2.10.5.1.2. For non-English speaking Enrollees, a choice of at least two PCPs, and at least two Behavioral Health Providers within each Behavioral Health Covered Service category set forth in **Appendix C**, in the Prevalent Languages in the Service Area provided that such provider capacity exists within the Service Area.

2.10.5.2. The Contractor shall provide culturally competent services, including by:

2.10.5.2.1. Ensuring that Network Providers are responsive to the linguistic, cultural, ethnic, or other individual needs of all Enrollees, homeless individuals, and other sub-populations served under the Contract;

2.10.5.2.2. Identifying 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;

2.10.5.2.3. Participating in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, various disabilities and chronic medical conditions, and regardless of gender, sexual orientation, or gender identity;

2.10.5.2.4. Employing or contracting with Community Health Workers, or contracting with provider organizations employing CHWs, to connect with Enrollees through shared cultural, linguistic, and lived experience, and perform outreach, health literacy education, health coaching, and other support activities appropriate to the CHW's training and skill sets.

2.10.6. Direct Access to Specialists

2.10.6.1. The Contractor shall have a mechanism to identify Enrollees that need a course of treatment or regular care monitoring, to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.

2.10.7. Additional Requirements

2.10.7.1. The Contractor shall 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 shall include, but not be limited to the Enrollee's private residence, a nursing or assisted living facility, and adult day programs.

2.10.7.2. The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or MassHealth fee-for-service if the provider serves only Enrollees or other persons eligible for MassHealth.

2.10.7.3. The Contractor shall meet the EOHHS standards for network adequacy, as applicable, including access and availability, provided, however, the Contractor may request an exception to the EOHHS standards set forth in this **Section 2.10** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to, or more permissive than, the usual and customary community standards applicable in Massachusetts for accessing care. Upon approval by EOHHS, the Contractor shall notify Enrollees in writing of such alternative access standards.

2.10.7.4. The Contractor shall have a system in place to monitor, verify, and document meeting access and availability, including appointment scheduling standards and wait times.

2.10.7.4.1. Such system shall include “secret shopper” activities, as further specified by EOHHS.

2.10.7.4.2. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/access standards specified above in **Section 2.10.2** and shall promptly address any access deficiencies. Annually, in accordance with **Appendix A**, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in **Section 2.10.2**.

2.10.7.5. The Contractor shall evaluate and report on its compliance with the access and availability standards and on its "secret shopper" and other verification activities in accordance with **Appendix A**. The Contractor shall ensure all information submitted in such reports are up-to-date, accurate, and complete, including but not limited to information contained in any Provider directories and Provider lists.

2.10.7.6. The Contractor shall develop and submit by May 1, 2025, to EOHHS for Approval a Network Access Monitoring and Dental Caseload Capacity Plan including, at minimum, the following elements:

2.10.7.6.1. A description of network access monitoring activities to be conducted at least quarterly to ensure that Contract’s access requirements are met;

2.10.7.6.1.1. Monitoring activities shall include a Secret Shopper program wherein Contractor selects a representative, statistically valid sample of Dental Provider practices and assigns staff to call, posing as MassHealth Members, and ask to make an appointment;

2.10.7.6.1.2. Secret Shoppers shall record whether the information listed on the Provider Directory for each Provider is correct, with a focus on the Provider’s Accepting Patients Status;

2.10.7.6.1.3. Secret Shoppers shall record Wait Times;

2.10.7.6.2. Applying the EOHHS-Approved methodology, electronically track and report on a cumulative basis to EOHHS monthly, quarterly and annually the number of Dental Providers who close their practice to accepting new Members. Contractor shall include the following details for each such Provider: name, address, County, service type (individual Dental Provider or group), specialty and effective date as MassHealth Provider;

2.10.7.6.3. A proposed format for reporting on the findings of monitoring activities to EOHHS within thirty (30) days of the end of the quarter, including how Contractor intends to address issues identified as part of these activities.

2.10.7.6.4. Quarterly (with each quarter's data compared to the previous quarter), on February 28, May 31, August 31 and November 30 (or if any such date is not a Business Day, the next Business Day) of each Contract year, report to EOHHS:

2.10.7.6.5. Findings from network access monitoring activities and how Contractor intends to address issues identified as part of these activities;

2.10.7.6.5.1. The ratio of Dental Providers to Members for each County;

2.10.7.6.5.2. Average distance a Member must travel;

2.10.7.6.5.3. Number of Members with paid services; and

2.10.7.6.5.4. The number of new Dental Providers who have limited their caseload upon joining if data is available.

2.10.7.6.5.5. Each quarter this report shall include a written narrative identifying the Counties that are the most affected by new limits to caseload given the pre-existing Provider/Member ratio and travel distance and a description of recruitment efforts planned for the communities/Counties that show a 10% or greater increase in Dental Provider-to-Member ratio or average travel distance.

2.10.7.7. When a PCP or any medical, behavioral health or LTSS provider is terminated from the Contractor's SCO Plan or leaves the network for any reason, the Contractor shall make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received their care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor shall also report the termination to EOHHS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.10.7.8. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the Contractor shall remove it from the formulary immediately. The Contractor shall make a good faith effort to give written

notification of removal of this drug from the formulary and the reason for its removal, within five (5) days after the removal, to each Enrollee with a current or previous prescription for the drug. The Contractor shall also make a good faith effort to call, within three (3) calendar days, each Enrollee with a current or previous prescription for the drug. A good faith effort shall involve no fewer than three phone call attempts at different times of the day and days of the week including on weekends.

2.10.7.9. 72-Hour Medication Supply

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

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

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

2.10.8. Accessibility and Accommodations

2.10.8.1. General

2.10.8.1.1. The Contractor shall identify to EOHHS the Accessibility and Accommodations Officer, i.e., the individual in its organization who is responsible for accessibility and accommodations compliance related to the Contractor's SCO plan, and for evaluating and ensuring adequate access to Covered Services and Network Providers for all Enrollees as described in this **Section 2.10.8**.

2.10.8.1.2. The Accessibility and Accommodations Officer shall also be responsible for monitoring the processes described in **Section 2.10.8.2** and **Section 2.10.8.3** and shall use data produced pursuant to **Section 2.10.8.3.1.11**. to evaluate and improve such processes, policies, and procedures as needed, and shall participate in the Contractor's SCO Advisory Board.

2.10.8.2. Processes to Overcome Barriers

2.10.8.2.1. The Contractor shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities and/or with diverse ethnic and cultural backgrounds from obtaining all Covered Services from the Contractor by:

2.10.8.2.1.1. Providing flexibility in scheduling to accommodate the needs of Enrollees,

2.10.8.2.1.2. Ensuring that Enrollees are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services, which shall be made available upon request of the potential Enrollee or Enrollee at no cost and that Enrollees can make standing requests for reasonable accommodations. Reasonable accommodations will depend on the particular needs of the individual and include:

2.10.8.2.1.2.1. Providing large print (at least eighteen (18)-point font) or Braille of all written materials to individuals with visual impairments, as requested;

2.10.8.2.1.2.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.10.8.2.1.2.3. Reading notices and other written materials to individuals upon request;

2.10.8.2.1.2.4. Assisting individuals in filling out forms over the telephone;

2.10.8.2.1.2.5. Ensuring effective communication to and from Enrollees in accordance with their communication preferences, including through email, telephone, text, and other electronic means;

2.10.8.2.1.2.6. Ensuring effective communication to and from individuals who are Deaf or hard of hearing, or who have disabilities impacting their speech or communication needs, by using these individuals' preferred modes of communication access through email, text, telephone, and other electronic means, and through services and technologies such as TTY, Video Relay Services (VRS), computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays, qualified interpreters (including ASL interpreters), and other auxiliary aids and services;

2.10.8.2.1.2.7. Providing interpreters or translators for Enrollees whose primary language is not English;

2.10.8.2.1.3. Providing accessible equipment such as exam tables, weight scales, and diagnostic equipment;

2.10.8.2.1.4. Providing individualized forms of assistance;

2.10.8.2.1.5. Ensuring safe and appropriate physical access to buildings, services, and equipment;

2.10.8.2.1.6. Conducting annual independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance, and monitoring correction of deficiencies to ensure compliance with the applicable State and federal laws and regulations governing accessibility and accommodations; and

2.10.8.2.1.7. Developing, executing, and annually updating a work plan to achieve and maintain accessibility and accommodations compliance and submit the work plan in a form and format as specified in **Appendix A**.

2.10.8.3. Processing Enrollee Requests

2.10.8.3.1. The Contractor shall have written policies and procedures to ensure clear processes for Enrollees to make, and for the Contractor to respond to, accessibility and accommodation requests, which shall depend on the particular needs of the Enrollee, including:

2.10.8.3.1.1. How Enrollees shall be informed of such processes;

2.10.8.3.1.2. How Enrollees may make a request for accessibility or accommodations to their Provider or the Contractor;

2.10.8.3.1.3. How Enrollees may make standing requests for continued accessibility or accommodations to their Provider or the Contractor;

2.10.8.3.1.4. Accepting and documenting all such requests, including in the Enrollee’s Centralized Enrollee Record;

2.10.8.3.1.5. Policies and procedures for evaluating such requests;

2.10.8.3.1.6. Internal escalation procedures for evaluating and resolving requests;

2.10.8.3.1.7. Responding timely to all such requests, including communicating the outcome to the Enrollee;

2.10.8.3.1.8. Documenting the approved action in the Enrollee's Centralized Enrollee Record;

2.10.8.3.1.9. Communicating approved actions to the Enrollee's Providers, Material Subcontractors or others as appropriate for implementation;

2.10.8.3.1.10. Procedures for Enrollees to escalate a request to the Accessibility and Accommodations Officer or their designee; and

2.10.8.3.1.11. Tracking and reporting on accessibility and accommodations requests, their status, and their outcomes.

2.10.9. Authorization of Services

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

2.10.9.1.1. For the processing of Service Requests for initial and continuing authorizations of services, the Contractor shall:

2.10.9.1.1.1. Have in place and follow written policies and procedures;

2.10.9.1.1.2. Ensure that its service authorization processes use the expanded definition of Medical Necessity in **Section 1** of this Contract;

2.10.9.1.1.3. Have in place procedures to allow Enrollees, authorized representatives, GSSCs or other designate care coordinators or designees, and providers to initiate requests for provisions of services;

2.10.9.1.1.4. Have policies and procedures to ensure Service Requests are processed in accordance with the required timelines outlined in **Section 2.10.9.8**;

2.10.9.1.1.5. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.10.9.1.1.6. Authorize services to reflect a Member's assessment and their ICP;

2.10.9.1.1.7. Have in place an authorization process for the covered Long-term Services and Supports (LTSS) in **Section 2.7** and defined in **Appendix C**; and

2.10.9.1.1.8. Consult with the Enrollee and requesting provider when appropriate.

2.10.9.2. In evaluating requests for LTSS, the Contractor shall consider continuity of care. If a service, level of service, or equipment has been part of the Enrollee's life routine over an extended period and is integral to their overall care and independence structure, any denial or reduction in amount, duration, frequency, or scope of that service/equipment/supply must be supported in the ICP to ensure that such changes will not cause diminished ability for independent living and be consistent with the overall goals and needs of the enrollee as expressed in the ICP.

2.10.9.3. The Contractor shall ensure that a PCP and a Behavioral Health Provider are available twenty-four (24) hours a day for timely authorization of all Medically Necessary Services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. Such individuals shall be familiar with the Massachusetts delivery system, standards and practices of care in Massachusetts, and best practices in the types of services they authorize. The Contractor shall ensure that its guidelines for Medically Necessary Services and service authorization processes use the expanded definition of Medical Necessity in **Section 1** and **Section 2.7.2** and shall, at a minimum, be no more restrictive than the cumulative effect of the combined Medicare and Medicaid scopes of services.

2.10.9.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, as well as type or frequency, that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment, and who is familiar with the Massachusetts delivery system, the standards and practices of care in Massachusetts, and best practices in the types of services they authorize. In addition to the foregoing requirements, Behavioral Health Services denials shall be rendered by board-certified or board eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health Services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.10.9.5. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u2(b)(8). The Contractor shall comply with the requirements for

demonstrating parity for both cost sharing (copayments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.10.9.6. The Contractor shall authorize PCA Services to meet Enrollees' needs for assistance with ADLs and IADLs. The Contractor may consider the Enrollee's need for physical assistance as well as cueing or monitoring in order for the Enrollee to perform an ADL or IADL. Authorizations shall consider the medical and independent living needs of the Enrollee.

2.10.9.7. The Contractor shall notify the requesting provider, either orally or in writing, and give the Enrollee or authorized representative written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope, as well as type or frequency, that is less than requested. The written notice shall meet the requirements of 42 C.F.R. § 438.404 and **Section 2.13.4.3**, and shall:

2.10.9.7.1. Be produced in a manner, format, and language that can be easily understood;

2.10.9.7.2. Be made available in Prevalent Languages, upon request, including a standing request in the Enrollee's Centralized Enrollee Record;

2.10.9.7.3. Include information, in the most commonly used languages about how to request translation services, Alternative Formats, and the availability of auxiliary aids and services; and

2.10.9.7.4. Be documented in the Enrollee's Centralized Enrollee Record.

2.10.9.8. Authorization Timeframes

2.10.9.8.1. The Contractor shall make authorization decisions in the following timeframes:

2.10.9.8.1.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than seven (7) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.10.9.8.1.2. The Enrollee, authorized representative, or the provider requests an extension; or

2.10.9.8.1.3. The Contractor can justify (to the satisfaction of EOHHS) that:

2.10.9.8.1.3.1. The extension is in the Enrollee's interest; and

2.10.9.8.1.3.2. There is a need for additional information where:

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

2.10.9.8.1.3.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.10.9.8.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in **Section 2.10.9.8.1.1** above could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.10.9.8.2.1. The Enrollee or the provider requests an extension, or the Contractor can justify (to EOHHS) that:

2.10.9.8.2.1.1. The extension is in the Enrollee's interest; and

2.10.9.8.2.1.2. There is a need for additional information where:

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

2.10.9.8.2.1.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.10.9.8.3. When a service authorization decision is not reached within the applicable timeframe for either standard or expedited requests:

2.10.9.8.3.1. The Contractor shall give Notice of an extension the date that the time frame expires. Any failure by the Contractor provide timely notice of a service authorization decision in a timely manner may be subject to a corrective action plan or intermediate sanctions in accordance with **Section 5.4**.

2.10.9.8.3.2. Any extension of the required time frame for authorization decisions shall be documented in the Enrollee's Centralized Enrollee Record.

2.10.9.8.3.3. When the service authorization decision requested is for a service previously authorized for the Enrollee or that the Enrollee is receiving at the time of the request for authorization, the Contractor shall authorize or extend authorization of the service:

2.10.9.8.3.3.1. For the duration of extended time frame; and

2.10.9.8.3.3.2. Until the resolution of and in accordance with all advance notice and applicable Appeal actions that apply for a termination of service.

2.10.9.8.4. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the Contractor shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

2.10.10. Services Not Subject to Prior Approval

2.10.10.1. The Contractor shall not require prior approval for the following services:

2.10.10.1.1. Any services for Emergency Medical Conditions as defined in 42 C.F.R 422.113(b)(1) and 438.114(a) (which includes emergency Behavioral Health care);

2.10.10.1.2. Any Inpatient Mental Health services as set forth in **Appendix C**. The Contractor shall require Providers of Inpatient Mental Health services to provide the Contractor, within seventy-two (72) hours of an Enrollee's admission, with notification of admission of an Enrollment and an initial treatment plan for such Enrollee;

2.10.10.1.3. Urgent Care sought outside of the Service Area;

2.10.10.1.4. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.10.10.1.5. Family planning services;

2.10.10.1.6. Out of area renal dialysis services;

2.10.10.1.7. Dental services that MassHealth or its TPA exclude from Prior Authorization, as specified in 130 CMR 420 and in Subchapter 6 of MassHealth's Dental Manual;

2.10.10.1.8. Outpatient Services for covered substance use disorder treatment services;

2.10.10.1.9. The following Behavioral Health Outpatient Services, as defined in **Appendix C**: Couples/Family Treatment, Group Treatment, Individual Treatment, and Ambulatory Detoxification (Level 2.d);

2.10.10.1.10. Structured Outpatient Addiction Program (SOAP), as defined in **Appendix C**;

2.10.10.1.11. Intensive Outpatient Program (IOP), as defined in **Appendix C**; and

2.10.10.1.12. Partial Hospitalization (PHP), as defined in **Appendix C**;

2.10.10.1.13. American Society of Addiction Medicine Level 2.5, with short-term day or evening mental health programming available seven (7) days per week;

2.10.10.1.14. Clinically Managed Population-Specific High Intensity Residential Services (ASAM Level 3.3), as defined in **Appendix C**, as directed by EOHHS;

2.10.10.1.15. Transitional Support Services (TSS) for Substance Use Disorders, Population Specific High Intensity Residential Services, and Residential Rehabilitation Services (RRS) (ASAM Level 3.1), (ASAM Level 3.1), as defined in **Appendix C**, as directed by EOHHS;

2.10.10.1.16. Additional SUD Treatment Services in accordance with **Section 2.9.3.1.**

2.10.10.1.17. 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. The 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 people and individuals allergic to naloxone, provided such limitations are clinically appropriate.

2.10.10.1.18. Inpatient Substance Use Disorder Services (ASAM Level 4);

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

2.10.10.1.20. Clinical Stabilization Services for Substance Use Disorders (ASAM Level 3.5). Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;

2.10.10.1.21. Recovery Coach; and

2.10.10.1.22. Recovery Support Navigator.

2.10.11. Value and Outcomes in Service Authorization and Utilization Management

2.10.11.1. The Contractor's approach to service authorizations and Utilization Management, including for the services described in **Appendix C**, shall consider value, including how, as part of the Enrollee's ICP, the services:

2.10.11.1.1. Contribute to the health, independent living, and quality outcomes of the Enrollee;

2.10.11.1.2. Support the Enrollee's connection to, and ability to, participate in their community, and reduce social isolation; and

2.10.11.1.3. Improve or extend the Enrollee's overall capacity and/or function (e.g., such as by enabling Enrollee to allocate energy consistent with their goals and priorities or addressing related barriers and challenges).

2.10.11.2. Authorization of services and Utilization Management policies and procedures shall incorporate:

2.10.11.2.1. Consideration of expected individual outcomes, e.g., whether services as part of the ICP would:

2.10.11.2.1.1. Meet the particular needs of the Enrollee;

2.10.11.2.1.2. Support the Enrollee's ability to live independently and participate in their home life and their community; and

2.10.11.2.1.3. Use preventive approaches and proactive strategies to shift utilization from acute care and other facility settings to community settings, including diverting from, preventing, or avoiding stays or visits in facility settings, hospitals, or emergency departments.

2.10.11.2.2. Individualized clinical standards for Members with medical or Behavioral Health conditions, environmental circumstances, Social Determinant of Health needs, and/or accessibility or communication needs for which population-based clinical standards are not appropriate or are insufficient.

2.10.11.3. Authorization of services and Utilization Management policies and procedures shall encourage proactive, preventive strategies to prevent and avoid the need for acute care;

2.10.11.4. The Contractor's One Care Plan shall connect Enrollees to community organizations that can provide additional resources and support for Enrollees, and authorize accessibility, communication, and transportation services as needed to provide access to this additional support; and

2.10.11.5. The Contractor shall measure and report on its effectiveness in improving outcomes for its Enrollees as described in this **Section 2.10.11**, including as part of EOHHS's quality measurement approach and requirements.

2.10.12. Utilization Management

2.10.12.1. The Contractor shall maintain a utilization management plan and procedures consistent with the following:

2.10.12.1.1. Staffing of all Utilization Management activities shall include, but not be limited to, a medical director, or medical director's designee. The Contractor shall also have a medical director's designee for behavioral health Utilization Management.

2.10.12.1.2. The Contractor's accountable designee(s) and staff conducting Utilization Management activities applied to the SCO Plan shall be credentialed in Massachusetts, and shall be familiar with the Massachusetts delivery system, the standards and practices of care in Massachusetts, and best practices for service delivery, and shall be accountable to the SCO Plan's local management team in Massachusetts.

2.10.12.1.3. Such accountable designee for Utilization Management shall participate in the Contractor's SCO Consumer Advisory Board.

2.10.12.1.4. All of the Contractor's Utilization Management team members, including the accountable designees, shall:

2.10.12.1.4.1. Be in compliance with all federal, State, and local professional licensing requirements;

2.10.12.1.4.2. Include representatives from appropriate specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, psychiatry, and substance use disorders (e.g., addictionology);

2.10.12.1.4.3. Not have had any disciplinary actions or other type of sanction ever taken against them, in any state or territory, by the relevant professional licensing or oversight board or the Medicare and Medicaid programs; and

2.10.12.1.4.4. Not have any sanctions relating to their professional practice including, but not limited to, malpractice actions resulting in entry of judgment against them, unless otherwise agreed to by EOHHS.

2.10.12.1.5. In addition to the requirements set forth in **Section 2.10.9**, the medical director's designee for Behavioral Health utilization management shall also:

2.10.12.1.5.1. Be board-certified or board-eligible in psychiatry;

2.10.12.1.5.2. Be available twenty-four (24) hours per day, seven days a week for consultation and decision-making with the Contractor's clinical staff and providers; and

2.10.12.1.5.3. Meet the requirements, and ensure its staff meet the requirements, set forth in **Section 2.10.12.5**.

2.10.12.2. Reserved

2.10.12.3. The Contractor shall have in place policies and procedures that include at a minimum the elements listed below. The Contractor shall submit such policies and procedures to EOHHS upon request.

2.10.12.3.1. Routinely assess the effectiveness and the efficiency of the utilization management program;

2.10.12.3.2. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, Behavioral Health treatments, pharmacy formularies and devices;

2.10.12.3.3. Target areas of suspected inappropriate service utilization;

2.10.12.3.4. Detect over- and under-utilization;

2.10.12.3.5. Routinely generate provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

2.10.12.3.6. Compare Enrollee and provider utilization with norms for comparable individuals and Network Providers;

2.10.12.3.7. Routinely monitor inpatient admissions, emergency department use, ancillary, out-of-area services, and out-of-network services, as well as Behavioral Health inpatient and outpatient services, diversionary services, and Mobile Crisis Intervention Services;

2.10.12.3.8. Ensure that treatment and discharge planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other providers, and other supports identified by the Enrollee as appropriate;

2.10.12.3.9. Conduct retrospective reviews of the medical records of selected cases to assess the medical necessity, clinical appropriateness of care, and the duration and level of care;

2.10.12.3.10. Refer suspected cases of provider or Enrollee fraud or abuse to EOHHS;

2.10.12.3.11. Address processes through which the Contractor monitors issues around services access and quality identified by the Contractor, EOHHS, Enrollees, and providers, including the tracking of these issues and resolutions over time; and

2.10.12.3.12. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.

2.10.12.4. The Contractor’s utilization management activities shall include:

2.10.12.4.1. Referrals and coordination of Covered Services;

2.10.12.4.2. Authorization of Covered Services, including modification or denial of requests for such services;

2.10.12.4.3. Assisting care teams and providers to effectively provide inpatient Discharge Planning;

2.10.12.4.4. Behavioral Health treatment and discharge planning;

2.10.12.4.5. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health Services;

2.10.12.4.6. Providing training and supervision to the Contractor’s utilization management clinical staff and Providers on:

2.10.12.4.6.1. The standard application of medical necessity criteria and utilization management policies and procedures to ensure that staff maintain and improve their clinical skills;

2.10.12.4.6.2. Utilization management policies, practices and data reported to the Contractor to ensure that it is standardized across all providers within the Contractor's Provider Network;

2.10.12.4.6.3. The consistent application and implementation of the Contractor's clinical criteria and guidelines including the Behavioral Health clinical criteria approved by EOHHS;

2.10.12.4.6.4. Monitoring and assessing all Behavioral Health Services and outcomes measurement, using any standardized clinical outcomes measurement tools to support utilization management activities; and

2.10.12.4.6.5. The Contractor's Behavioral Health Services Provider Contracts shall stipulate that the Contractor may access, collect, and analyze such behavioral health assessment and outcomes data for quality management and Network Management purposes, and

2.10.12.4.6.6. Care management programs.

2.10.12.5. The Contractor shall ensure that clinicians conducting utilization management who are coordinating Behavioral Health Services, and making Behavioral Health service authorization decisions, have training and experience in the specific area of Behavioral Health service for which they are coordinating and authorizing Behavioral Health Services. The Contractor shall ensure the following:

2.10.12.5.1. That the clinician coordinating and authorizing mental health services shall be a clinician with experience and training in mental health services and recovery principles;

2.10.12.5.2. That the clinician coordinating, and authorizing substance use disorders shall be a clinician with experience and training in substance use disorders; and

2.10.12.5.3. That the clinician coordinating and authorizing services for Enrollees with co-occurring disorders shall have experience and training in co-occurring disorders.

2.10.12.6. The Contractor shall have policies and procedures for its approach to retrospective utilization review of providers. Such approach shall

include a system to identify utilization patterns of all providers by significant data elements and established outlier criteria for all services.

2.10.12.7. The Contractor shall have policies and procedures for conducting retrospective and peer reviews of a sample of providers to ensure that the services furnished by providers were provided to Enrollees, were appropriate and medically necessary or otherwise indicated in the Enrollee's care plan and evaluated in accordance with **Section 2.10.11** and were authorized and billed in accordance with the Contractor's requirements.

2.10.12.8. The Contractor shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than five hundred (500) Enrollees to ensure that such Enrollees received the services for which providers billed with respect to such Enrollees and shall report the results of such review to EOHHS as requested.

2.10.12.9. The Contractor shall monitor and ensure that all Utilization Management activities provided by a Material Subcontractor comply with all provisions of this Contract.

2.10.12.10. The Contractor shall participate in any workgroups, task forces, and meetings related to Utilization Management and best practices, as requested by EOHHS. The Contractor shall review and align its Utilization Management policies and procedures to align with any recommendations of such group.

2.10.12.11. The Contractor shall submit an annual report of Enrollees who have been enrolled in the Contractor's Plan for one year or more with no utilization. The report shall include an explanation of outreach activities to engage these Enrollees (see Appendix A).

2.10.12.12. If utilization management review activities are performed for Acute Treatment Services (ASAM level 3.7) or Clinical Stabilization Services for Substance Use Disorders (ASAM level 3.5), such activities shall comply with Section 10H of Chapter 118E of the General Laws. For ASAM level 3.5, specify that such activities may be performed no earlier than day seven (7) of the provision of such services, including but not limited to discussions about coordination of care and discussions of treatment plans. The Contractor may not make any utilization management review decisions that impose any restriction or deny any future Medically Necessary Clinical Stabilization Services for Substance Use Disorders (Level 3.5) unless an Enrollee has received at least fourteen (14) consecutive days of Clinical Stabilization Services for Substance Use Disorders (Level 3.5). Any such decisions shall follow the requirements set forth in **Section 2.13** regarding the transmission of

adverse determination notifications to Enrollees and clinicians and processes for internal and external Appeals of Contractor's decisions.

2.10.12.13. The Contractor shall not impose concurrent review and deny coverage for ATS based on utilization review; however, the Contractor may contact providers of ATS to discuss coordination of care, treatment plans, and after care.

2.10.12.14. The Contractor shall not establish utilization management strategies that require Enrollees to 'fail-first' or participate in 'step therapy' as a condition of providing coverage for injectable naltrexone (VivitrolTM). The Contractor shall cover VivitrolTM as a pharmacy and medical benefit. If the Contractor covers VivitrolTM as a specialty pharmacy benefit, the Contractor shall allow Enrollees to do a first fill at any pharmacy, not just at specialty pharmacies. First fill is defined as a new start or a re-initiation of therapy.

2.10.12.15. To the extent that an Enrollee receives Naltrexone in a provider setting that is billable under the medical benefit rather than under the pharmacy benefit, then the Contractor shall cover the Naltrexone as a medical benefit.

2.10.13. Behavioral Health Service Authorization Policies and Procedures

2.10.13.1. The Contractor shall review and update annually, at a minimum, the Behavioral Health clinical criteria definitions and program specifications for each Covered Service. The Contractor shall submit any modifications to EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with its clinical staff or medical consultants outside of the Contractor's organization, or both, who are familiar with standards and practices of mental health and substance use disorder treatment in Massachusetts and best practices in these treatment areas.

2.10.13.2. The Contractor shall review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies and procedures.

2.10.13.3. The Contractor shall develop and maintain Behavioral Health Inpatient Services and Diversionary Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

2.10.13.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission or Diversionary Service, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week;

2.10.13.3.2. A plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;

2.10.13.3.3. For all Behavioral Health emergency inpatient admissions, ensure:

2.10.13.3.3.1. A system to provide an initial authorization and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician for all Behavioral Health emergency inpatient admissions verbally within thirty (30) minutes, and within two (2) hours for non-emergency inpatient authorization and in writing within twenty-four (24) hours of admission;

2.10.13.3.3.2. Policies and procedures to ensure compliance by the Contractor and any of the Contractor's Material Subcontractors with the above **Section 2.10.13.3.3.1**;

2.10.13.3.4. Processes to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed;

2.10.13.3.5. A system to concurrently review Behavioral Health Inpatient Services to monitor Medical Necessity for the need for continued stay, and achievement of Behavioral Health Inpatient Services treatment goals;

2.10.13.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and Diversionary Services treatment plans;

2.10.13.3.7. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other Members of the care team, and other providers, such as community-based mental health services providers, as appropriate;

2.10.13.3.8. Retrospective reviews of the medical records of selected Behavioral Health Inpatient Services admissions and 24-hour Diversionary Services cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care; and

2.10.13.3.9. Monitor the rates of authorization, diversion, modification and denial at the service level for each such service, and for reporting to EOHHS in accordance with **Appendix A**.

2.10.13.4. The Contractor shall develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

2.10.13.4.1. Policies and procedures to automatically authorize at least twelve (12) Behavioral Health Outpatient Services;

2.10.13.4.2. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial twelve (12) Outpatient Services;

2.10.13.4.3. Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health Clinical Criteria; and

2.10.13.4.4. Policies and procedures based upon Behavioral Health Clinical Criteria, to review and approve or deny all requests for Behavioral Health Outpatient Services based on Clinical Criteria.

2.10.13.4.5. A plan and system in place to direct Enrollees to the least intensive clinically appropriate service.

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

2.10.13.4.7. The Contractor shall develop and maintain SUD Services policies and procedures which shall include, but not be limited to, the following:

2.10.13.4.7.1. Require that Providers providing Clinical Stabilization Services for Substance Use Disorders (Level 3.5) and ATS shall provide the Contractor, within forty-eight (48) hours of a Covered Individual's admission, with notification of admission of a Covered Individual and an initial treatment plan for such Covered Individual. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Covered Individual, information regarding the Covered Individual's coverage with the Contractor, and the provider's initial treatment plan. The Contractor may not use failure to provide such notice as the basis for denying claims for services provided.

2.10.13.4.7.2. Allow for at least the first ninety (90) days of Residential Rehabilitation Services for a Covered Individual to occur

without prior approval, provided however that the Contractor may establish notification or registration procedures during the first ninety (90) days of Residential Rehabilitation Services. The Contractor shall submit for EOHHS's approval the Contractor's authorization and concurrent review procedures for Residential Rehabilitation Services.

2.10.14. Authorization of LTSS and Community-based Services

2.10.14.1. At a minimum, the Contractor's authorizations of LTSS listed in **Appendix C, Exhibit 1**, shall be no more limiting than MassHealth FFS authorization criteria for those Covered Services.

2.10.14.2. The Contractor shall not limit the amount, duration, or scope of services described in the Frail Elder Waiver (FEW) for the purposes of Utilization Management or other utilization controls.

2.10.14.3. The Contractor has discretion to cover other community-based services not listed in **Appendix C** if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care, considering the Enrollee's entire ICP.

2.10.14.4. As used in this **Section 2.10.14**, value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care, and institutional long-term care.

2.11. Enrollee Services

2.11.1. Enrollee Services Department

2.11.1.1. The Contractor shall:

2.11.1.1.1. Maintain an Enrollee services department to assist Enrollees, Enrollees' family members or guardians, and other interested parties in learning about and obtaining services under this Contract;

2.11.1.1.2. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives;

2.11.1.1.3. Ensure that Enrollee services department staff have access to:

2.11.1.1.3.1. The Contractor's Enrollee database;

2.11.1.1.3.2. EOHHS's Eligibility Verification System (EVS); and

2.11.1.1.3.3. An electronic provider directory that includes, but is not limited to, the information specified in **Section 2.8.7** of this Contract.

2.11.1.1.4. Employ Enrollee Services Representatives (ESRs) trained to answer Enrollee inquiries and concerns from Enrollees and Eligible MassHealth Members. ESRs shall:

2.11.1.1.4.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;

2.11.1.1.4.2. Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;

2.11.1.1.4.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device or telephone translation service;

2.11.1.1.4.4. Inform callers that interpreter services are free;

2.11.1.1.4.5. Make oral interpretation services available free of charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.11.1.1.4.6. Maintain the availability of services, such as TTY services, computer aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.11.1.1.4.7. Demonstrate sensitivity to culture, including the Independent Living Principles;

2.11.1.1.4.8. Provide assistance to Enrollees with cognitive impairments, for example, provide written materials in simple, clear language at a reading level of grade six (6) and below, and individualized guidance from Enrollee Services Representatives to ensure materials are understood; and

2.11.1.1.4.9. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor.

2.11.1.1.5. Ensure that ESRs make available to Enrollees and Eligible Enrollees, upon request, information concerning the following:

2.11.1.1.5.1. The identity, locations, qualifications, accessibility, and availability of providers;

2.11.1.1.5.2. Enrollees' rights and responsibilities;

2.11.1.1.5.3. The procedures available to an Enrollee and provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Actions (denials);

2.11.1.1.5.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats and the availability of auxiliary aids and services;

2.11.1.1.5.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.11.1.1.5.6. The procedures for an Enrollee to change plans or to disenroll from the SCO Plan; and

2.11.1.1.5.7. Additional information that may be required by Enrollees and Eligible Enrollees to understand the requirements and benefits of the SCO Plan.

2.11.2. Enrollee Service Call Center

2.11.2.1. Hours of Operation

2.11.2.1.1. The Contractor shall operate a call center and toll-free Enrollee services telephone line consistent with the standards set forth in 42 C.F.R. § 422.111(h)(1) and 423.128(d)(1).

2.11.2.1.2. The Contractor may use alternative call center technologies on Saturdays, Sundays, and Federal holidays except New Year's Day. On New Year's Day, the Contractor shall operate a call center with ESRs available during normal business hours.

2.11.2.2. Responsiveness Standards

2.11.2.2.1. The Contractor shall ensure ESRs are available during normal business hours daily. The Contractor shall ensure responsiveness in accordance with the following standards:

2.11.2.2.1.1. Answer 90% of all Enrollee telephone calls within thirty (30) seconds and be able to provide reports indicating compliance with this requirement upon request of EOHHS. The Contractor shall have a process to measure the time

from which the telephone is answered to the point at which an Enrollee reaches an ESR;

2.11.2.2.1.2. Limit average hold time to two (2) minutes. The hold time is defined as the time spent on hold by callers following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting, before reaching a live person; and

2.11.2.2.1.3. Limit the disconnect rate of all incoming calls to five (5) %. The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the customer call center.

2.11.2.3. Customer Service Requirements

2.11.2.3.1. The Contractor shall ensure that its ESRs who are assigned to respond to SCO-specific inquiries:

2.11.2.3.1.1. Understand and have a working knowledge of MassHealth, Medicare, and the terms of the Contract between EOHHS and the Contractor, including the Covered Services as referenced in **Section 2.7** and defined in **Appendix C**,

2.11.2.3.1.2. Answer Enrollee Inquiries, including those related to enrollment status and accessing care;

2.11.2.3.1.3. Are trained in Grievances, Internal Appeals, Medicare IRE, and Medicaid BOH Appeals processes and procedures, as specified in **Section 2.13**, and are available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances and submitting Appeals;

2.11.2.3.1.4. Refer Enrollee inquiries that are of a clinical nature, but non-behavioral health, to clinical staff with the appropriate clinical expertise to adequately respond;

2.11.2.3.1.5. Refer Enrollee inquiries related to Behavioral Health to the Contractor’s behavioral health clinical staff except where said Inquiries are solely administrative in content. For the purposes of this **Section 2.11.2**, examples of administrative inquiries shall include requests for general information regarding particular Behavioral Health Providers such as their participation as Network Providers, their address or their hours of operation, and shall exclude any questions that require judgment by a Behavioral Health clinical professional to provide an adequate response; and

2.11.2.3.1.6. Refer Enrollee inquiries about Long-term Services and Supports, independent living supports, and community-based versus facility-based services to a LTS Coordinator, and actively support Enrollees to access LTS Coordinators.

2.11.3. Coverage Determinations and Appeals Call Center Requirements

2.11.3.1. The Contractor shall operate a toll-free call center with live customer service representatives available to respond to providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and prior authorizations).

2.11.3.2. The Contractor shall provide, via its toll-free call centers, opportunities for Enrollees to request Medicare and Medicaid covered benefits and services, including Medicare coverage determinations and redeterminations.

2.11.3.3. The call center shall operate consistent with the standards set forth in 42 C.F.R. § 422.111(h)(1) and 423.128(d)(1). The Contractor shall accept requests for Medicare or Medicaid coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.11.3.3.1. Indicates that the mailbox is secure;

2.11.3.3.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Member is making an expedited or standard request);

2.11.3.3.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests, and

2.11.3.3.4. For Appeals calls, articulates and follows a process for resolution within seventy-two (72) hours for expedited Appeal requests and thirty (30) calendar days for standard Appeal requests.

2.12. Marketing, Outreach, and Enrollee Communication Standards

2.12.1. General Requirements

2.12.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act, 42 C.F.R. §422.111, § 422 Subpart V, § 423 Subpart V, §423.120(b) and (c), §423.128, and § 438.10, and §438.104, the Medicare Communications and Marketing Guidelines as updated from time to time. Additionally, the Contractor shall comply with the following requirements and restrictions. EOHHS may add additional requirements and restrictions related to marketing at its discretion.

2.12.1.2. In conducting marketing, education, and enrollment activities, the Contractor shall:

2.12.1.2.1. Comply with the information requirements of 42 CFR 438.104 and 42 CFR 438.10 to ensure that, before enrolling, the individual receives from the Contractor accurate oral and written information they need to make an informed decision on whether or not to enroll. This information shall be presented in a language or format that is accessible to the individual.

2.12.1.2.2. Ensure that marketing materials are accurate and not misleading, and do not defraud enrollees, potential enrollees, or MassHealth.

2.12.1.2.3. Make available to EOHHS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible MassHealth Members.

2.12.1.2.4. Convene all educational, marketing, sales, and enrollment events at sites that are:

2.12.1.2.4.1. Within the Contractor's Service Area;

2.12.1.2.4.2. Physically accessible to Enrollees and Eligible MassHealth Members, including persons with disabilities and/or functional limitations; and

2.12.1.2.4.3. Physically accessible to and easy to reach for persons using public transportation.

2.12.1.2.5. Distribute and/or publish Marketing Materials throughout the Contractor's Service Area(s), as indicated in **Appendix F, Exhibit 1**, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials:

2.12.1.2.5.1. To only a portion of the Contractor's Service Area(s) outlined in **Appendix F, Exhibit 1**; or

2.12.1.2.5.2. Where the campaign relates to a local event (such as a health fair), to a single Provider (such as a hospital or clinic); and

2.12.1.2.6. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.

2.12.1.3. The Contractor may convene or appear at a health fair or community activity sponsored by the Contractor provided that the Contractor shall notify all EOHHS-contracted SCO plans and PACE Organizations of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted health plans choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted health plans. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:

2.12.1.3.1. Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

2.12.1.3.2. Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the Contractor's Plan.

2.12.1.4. The Contractor may participate in Health Benefit Fairs sponsored by EOHHS. Such Health Benefit Fairs will be held in accordance with **Section 3.3**.

2.12.1.5. Under no conditions shall a Contractor use MassHealth's Member database or a Provider's patient/customer database to identify and market its plan to MassHealth beneficiaries, unless otherwise specified or approved by EOHHS. The Contractor shall not share or sell Enrollee lists or Enrollee data with other persons or organizations for any purpose other than performance of the Contractor's obligations pursuant to this Contract.

2.12.1.6. The Contractor shall not market to or otherwise encourage One Care plan Enrollees who will remain eligible for One Care at age sixty-five (65) to disenroll from One Care and enroll in SCO.

2.12.1.7. The Contractor shall not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible MassHealth Members to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor. The Contractor shall not directly or

indirectly conduct door-to-door, telephone, email, texting, or other unsolicited contacts (with the exception of direct mail, which is permissible), nor shall Contractor employees or agents present themselves unannounced at an Enrollee's place of residence for marketing or "educational" purposes. Calls made by the Contractor to Dual Eligible individuals enrolled in the Contractor's other product lines, are not considered unsolicited direct contact and are permissible.

2.12.1.8. The Contractor shall not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that suggest or imply that:

2.12.1.8.1. The recipient shall enroll with the Contractor in order to obtain benefits or in order not to lose benefits, or the Contractor is endorsed by CMS, Medicare, Medicaid, the Federal government, EOHHS, or similar entity. Annually, the Contractor shall present its marketing plan to EOHHS for review and approval.

2.12.2. Agents and Brokers

2.12.2.1. The Contractor may perform marketing, education, and enrollment activities for the Contractor's SCO Plan through its employees ("Employed Agents") and through non-Contractor-employed, independent, or external organization-based agents and brokers ("External Brokers"), including when employed or contracted through a Field Marketing Organization ("FMO").

2.12.2.2. External Brokers shall be considered Material Subcontractors, and shall be subject to the requirements of **Section 2.3.5** except those in **Section 2.3.5.3** as follows:

2.12.2.2.1. The Contractor's subcontracts with External Brokers shall not be subject to prior EOHHS approval;

2.12.2.2.2. Instead of **Appendix K**, the Contractor shall submit to EOHHS compensation and contract information as described in **Section 2.12.2.7** below; and

2.12.2.2.3. For individually contracted External Brokers (i.e. those not employed or contracted through an FMO) with which the Contractor enters a uniform contract agreement, the Contractor shall comply with the requirements of **Section 2.12.2.7** by submitting its uniform contract agreement with a list of the individuals contracted through such agreement, including their names, addresses, contract effective dates, and any individualized compensation arrangements.

2.12.2.3. The Contractor remains accountable for the member experience and actions of Employed Agents and External Brokers engaging in

marketing, education, and enrollment activities for its SCO Plan. EOHHS in its discretion may impose sanctions as described in **Section 5.3.14** for instances where actions taken by the Contractor's Employed Agents and/or External Brokers do not comply with Contract requirements.

2.12.2.4. The Contractor shall ensure its contracts with External Brokers include the oversight, monitoring, data collection, data reporting, and remediation elements necessary to comply with the requirements of this Contract.

2.12.2.5. Training Requirements

2.12.2.5.1. In addition to Medicare- and DOI-required training, the Contractor shall require Employed Agents and External Brokers to complete additional training and demonstrate competency in key areas prior to engaging in marketing, education, and enrollment activities for the Contractor, and at least every two years thereafter. Such trainings shall include:

2.12.2.5.1.1. Eligible populations, including a description of the population characteristics, the range of health, functional, and other care needs of such populations, and how Eligible Individuals compare to other Medicare and MassHealth populations;

2.12.2.5.1.2. MassHealth programs, benefits, and coverage options available to Eligible Individuals, including MassHealth Fee-For-Service, One Care, PACE, and SCO, and the corresponding Medicare program, benefit, and coverage options for each;

2.12.2.5.1.3. Individualized health options resources for Eligible Individuals, including SHINE and the Ombudsman.

2.12.2.5.2. Trainings shall result in a thorough understanding of the MassHealth coverage options available to Eligible Individuals and the benefits to members of enrolling in an integrated care program (e.g. One Care, PACE, and SCO);

2.12.2.5.3. Upon EOHHS request, the Contractor shall submit to EOHHS the Contractor's training plan, including how the required topics described in **Section 2.12.2.4.1** are addressed, additional topics and requirements, materials and resources, competency testing, and compliance; and

2.12.2.5.4. The Contractor shall implement any EOHHS required updates to training requirements and materials.

2.12.2.6. Monitoring Plan

2.12.2.6.1. The Contractor shall develop and implement a plan (hereinafter referred to as the Monitoring Plan) to monitor the marketing, education, and enrollment activities undertaken by its Employed Agents and External Brokers with respect to the D-SNP products available to Eligible Individuals that are offered by the Contractor or an affiliate, parent organization, or subsidiary of the Contractor in Massachusetts (collectively, Contractor-related Organizations);

2.12.2.6.2. The Monitoring Plan shall be submitted to EOHHS upon EOHHS's request;

2.12.2.6.3. The Monitoring Plan shall include, but not be limited to, descriptions of:

2.12.2.6.3.1. The Contractor's staffing and resources responsible for monitoring Employed Agent and External Broker activities and performance;

2.12.2.6.3.2. Ongoing monitoring and compliance processes and standards for Employed Agent and External Broker activities;

2.12.2.6.3.3. Secret shopper activities and how the results from such monitoring will be used;

2.12.2.6.3.4. How the Contractor will prevent, monitor, and remediate the provision of misleading or inaccurate information to Eligible Members by Employed Agents and External Brokers;

2.12.2.6.3.5. How the Contractor will prevent, monitor, identify, and remediate outlier trends of Eligible Members disenrolling from the Contractor's SCO Plan into non-SNP Medicare products offered by the Contractor or a Contractor-related Organization;

2.12.2.6.3.6. How the Contractor will track and analyze the Eligible Member enrollment into its SCO Plan and into non-SNP Medicare products offered by the Contractor or a Contractor-related Organization;

2.12.2.6.3.7. The measures that the Contractor will impose to prevent coercion, misinformation, and any other practices that may mislead Members or otherwise violate Member rights or autonomy;

2.12.2.6.3.8. How the Contractor will monitor, audit, and otherwise ensure the quality and reliability of Employed Agents and External Brokers;

2.12.2.6.3.9. Data and analysis the Contractor will collect and conduct on marketing, education, and enrollment activities performed by Employed Agents and External Brokers;

2.12.2.6.3.10. How the Contractor will enforce Member rights and protections;

2.12.2.6.3.11. Compliance actions available for Employed Agents and External Brokers, including the criteria for triggering them, and how and when the compliance actions would be taken;

2.12.2.6.3.12. How the Contractor will ensure contracted External Brokers comply with CMS requirements under 42 U.S.C 1320a-7b(b), including the Contractor's strategy to prohibit various purported administrative and other add-on payments or amounts that cumulatively exceed the maximum compensation allowed under the current regulations; and

2.12.2.6.3.13. The process the Contractor will use to report concerning behavior or trends, Member concerns and Grievances, and confirmed or suspected Medicare violations or violations of EOHHS requirements in this **Section 2.12.2**, to CMS, EOHHS, and the Massachusetts Division of Insurance (DOI), as appropriate.

2.12.2.7. Compensation

2.12.2.7.1. The Contractor shall provide to EOHHS by September 1, 2025:

2.12.2.7.1.1. Compensation and incentive arrangements and structures for its Employed Agents and External Brokers (if any) for the Contractor's SCO Plan;

2.12.2.7.1.2. A description of how the Contractor's compensation arrangements shall ensure that enrollments into the Contractor's SCO Plan are similarly incentivized relative to enrollments into non-D-SNP Medicare products offered by the Contractor or Contractor-related Organizations;

2.12.2.7.1.3. A description of how the Contractor's compensation arrangements do not inappropriately incentivize Employed Agents and External Brokers to steer Eligible Individuals to enroll in any Medicare products offered by the Contractor other than the Contractor's SCO Plan; and

2.12.2.7.1.4. The Contractor's new and updated executed contracts with External Brokers (if changes to contracts have occurred since Readiness Review), including any compensation arrangements, upon EOHHS request.

2.12.2.8. Marketing, Education, and Enrollment Data

2.12.2.8.1. The Contractor shall provide the following information to EOHHS through the CMT Tracker as specified in **Section 2.3.2.2.3.1.15** and **Appendix A**:

2.12.2.8.1.1. Grievances and other feedback related to marketing, education, and enrollment activities, including the Contractor's responses and subsequent reporting to CMS, EOHHS, and DOI;

2.12.2.8.1.2. Enrollment outcomes and trends for Employed Agents and for External Brokers (if any);

2.12.2.8.1.3. Data and analysis from Secret Shopper activities described in **Section 2.12.2.6**; and

2.12.2.8.1.4. Additional information as may be required by EOHHS.

2.12.3. Communications Materials

2.12.3.1. The Contractor's Marketing, Outreach, and Enrollee Communications materials shall be:

2.12.3.1.1. Provided to Enrollees on a standing basis in Alternative Formats, upon receiving a request for materials in accessible format or when otherwise learning of the Enrollee's need for an accessible format for individuals with impaired sensory, manual, or speaking skills; and

2.12.3.1.2. Made available in Alternative Formats according to the needs of Enrollees and Eligible Beneficiaries, including Braille, oral interpretation services in non-English languages as specified in **Section 2.4.13** and this **Section 2.12.3**, audiotape, American Sign Language video clips, and other alternative media, as requested, and the availability of auxiliary aids and services.

2.12.3.2. Written materials shall be:

2.12.3.2.1. Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;

2.12.3.2.2. Provided in a manner, format, and language that may be easily understood by persons with limited English proficiency, or for those with

developmental disabilities or cognitive impairments, as required under 45 C.F.R. Part 92.101;

2.12.3.2.3. Made available in large print (at least 18-point font) to Enrollees as an Alternative Format;

2.12.3.2.4. Written with cultural sensitivity and at a sixth- grade reading level on average;

2.12.3.2.5. Translated into Prevalent Languages in the Service Area;

2.12.3.2.6. Sent in Spanish to Members whose primary language is known to be Spanish, if the materials are pre-enrollment or enrollment materials;

2.12.3.2.7. Mailed with Spanish, Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian, Vietnamese, French, Italian, Hindi, Greek, Korean, Polish, Arabic, and Gujarati taglines that alert Enrollees to the availability of language assistance services and auxiliary aides, free of charge, and how those services can be obtained;

2.12.3.2.8. As applicable, mailed with a non-discrimination notice or statement, consistent with the requirements of 45 C.F.R. Part 92; and

2.12.3.2.9. Developed utilizing definitions as specified by EOHHS and CMS, consistent with 42 C.F.R. § 438.10(c)(4)(i).

2.12.3.3. Submission, Review, and Approval

2.12.3.3.1. The Contractor shall receive approval from EOHHS, prior to use, for all marketing and Enrollee Communications materials specified by EOHHS and as described in **Section 2.12.3.5**.

2.12.3.3.2. EOHHS may conduct additional types of review of Contractor Marketing, Outreach, and Enrollee Communications materials and marketing, education, and enrollment activities, including, but not limited to:

2.12.3.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits or during unannounced visits;

2.12.3.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace;

2.12.3.3.2.3. “For cause” review of materials and activities when Grievances are made by any source, and EOHHS determines it is appropriate to investigate; and

2.12.3.3.2.4. “Secret shopper” activities where EOHHS requests Contractor materials, such as enrollment packets.

2.12.3.4. All Marketing, Outreach, and Enrollee Communications materials used and submitted for review for the Contractor’s SCO Plan shall be tailored for use for the Contractor’s SCO Plan. For example, marketing material should not refer Enrollees to “your state’s health department” but should instead be created specifically for Massachusetts (i.e., the Massachusetts Department of Public Health).

2.12.3.5. The Contractor shall submit all communication and marketing materials for categories specified in the Health Plan Management System (HPMS), as described in 42 CFR §§ 422.2267(d)(2)(i) and 423.2267(d)(2)(i), under the D-SNP Contractor’s Medicare contract H number, and in accordance with the following:

2.12.3.5.1. The multi-plan submission process is not applicable to D-SNP-only contracts.

2.12.3.5.2. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes enrollee-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization or a Y number for materials the third-party provides to D-SNP Enrollees in D-SNP-only contracts; and

2.12.3.5.3. The material shall be submitted in HPMS using a separate material ID number for the D-SNP-only contract and that material ID number shall be included in the material.

2.12.3.6. The Contractor shall use integrated material templates and integrated Notice templates for Massachusetts, in accordance with 42 CFR 422.107(e)(3), including for the materials specified in **Section 2.12.5.1.2**.

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

2.12.4.1. The Contractor shall not begin Marketing, Outreach, and Enrollee Communications activities to Eligible Individuals prior to October 1 for the upcoming Contract Year (e.g., October 1, 2025, for enrollments effective January 1, 2026).

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

2.12.5.1. General

2.12.5.1.1. The Contractor shall provide new Enrollees with the materials described in this **Section 2.12.5**, which, with the exception of the Summary of Benefits specified in **Section 2.12.5.3** and the ID card specified in **Section 2.12.5.5** below, shall also be provided annually thereafter.

2.12.5.1.2. The Contractor shall use Marketing and Communication Materials that integrate Medicare and Medicaid content, including at a minimum the Summary of Benefits (SB), List of Covered Drugs (Formulary), Provider and Pharmacy Directory (PPD), Annual Notice of Change (ANOC), Evidence of Coverage (EOC)/Member Handbook, and Member ID card, using integrated materials templates and content for the Massachusetts SCO program, and as directed by EOHHS and CMS.

2.12.5.2. A Member Handbook document, or a distinct and separate Notice on how to access the Member Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. § 438.10, includes information about all Covered Services, as outlined below, and that uses the integrated template for Massachusetts.

2.12.5.2.1. Enrollee rights (see **Appendix N**);

2.12.5.2.2. An explanation of how Enrollee records are stored and shared with key caregivers;

2.12.5.2.3. How to obtain a copy of the Enrollee's Record;

2.12.5.2.4. How to obtain access to specialty, behavioral health, pharmacy, oral health, and LTSS providers;

2.12.5.2.5. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area, including:

2.12.5.2.5.1. What constitutes emergency medical condition, Emergency Services, and Post- stabilization Services, with reference to the definitions is 42 C.F.R. § 438.114(a);

2.12.5.2.5.2. The fact that prior authorization is not required for Emergency Services;

2.12.5.2.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 or other emergency service hotlines;

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

2.12.5.2.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.12.5.2.6. How to access the Contractor's 24-hour Clinical Advice and Support Line required under **Section 2.7.8.4**;

2.12.5.2.7. Information on how to report suspected fraud or abuse;

2.12.5.2.8. The services provided by Community Behavioral Health Centers and how to access them;

2.12.5.2.9. How to access and use the Behavioral Health Help Line; and

2.12.5.2.10. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128, and § 438.3(j)), which information shall be updated to reflect any changes in Massachusetts law as soon as possible, but no later than ninety (90) days after the effective date of changes, including:

2.12.5.2.10.1. Enrollee rights under the laws of the Commonwealth;

2.12.5.2.10.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;

2.12.5.2.10.3. Grievances concerning noncompliance with the Advance Directive requirements may be filed with EOHHS;

2.12.5.2.10.4. Designating a health care proxy;

2.12.5.2.10.5. Other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and

2.12.5.2.11. How to obtain assistance from ESRs;

2.12.5.2.12. How to file Grievances and Internal and External Appeals, including:

2.12.5.2.12.1. Grievance, Appeal, and fair hearing procedures and timeframes;

2.12.5.2.12.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.12.5.2.12.3. How to access assistance in the filing process;

2.12.5.2.12.4. The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information;

2.12.5.2.12.5. A statement that if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing and, when requested by the Enrollee, benefits will continue at the plan level for all benefits;

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

2.12.5.2.12.7. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as EOHHS may identify, including an Ombudsman;

2.12.5.2.13. The extent to which, and how Enrollees may obtain benefits, including family planning services, from non-network providers;

2.12.5.2.14. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing in accordance with 42 C.F.R. § 447.50 through 42 C.F.R. § 447.60, and how transportation is provided;

2.12.5.2.15. How to change providers; and

2.12.5.2.16. How to disenroll voluntarily, including how to transfer from one SCO Plan to another.

2.12.5.3. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the SCO Plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the integrated template for Massachusetts. The Summary of Benefits shall provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;

2.12.5.4. A combined Provider and Pharmacy Directory that is consistent with the requirements in **Section 2.12.6**, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in § 422.2267(d)(2)(i) and § 423.2267(d)(2)(i);

2.12.5.5. A single member identification (ID) card for accessing all Covered Services under the plan;

2.12.5.6. A comprehensive, integrated List of Covered Drugs (formulary) that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the Commonwealth's outpatient prescription drug benefit and that uses the integrated template for Massachusetts, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in § 422.2267(d)(2)(i) and § 423.2267(d)(2)(i);

2.12.5.6.1. In accordance with 42 CFR 422.2267 and 423.2267, the Contractor shall provide Enrollees with at least thirty (30) days advance notice regarding specified changes to the comprehensive, integrated formulary; and

2.12.5.7. An Annual Notice of Change that summarizes all major changes to the Contractor's covered benefits from one contract year to the next and that uses the integrated template for Massachusetts.

2.12.6. Provider and Pharmacy Directory

2.12.6.1. Maintenance and Distribution

2.12.6.1.1. The Contractor shall:

2.12.6.1.1.1. Maintain and update a combined Provider and Pharmacy Directory that uses the integrated template for Massachusetts;

2.12.6.1.1.2. Provide either a copy or a separate notice on how to access the information online in a machine-readable file and format and how to request a hard copy, as specified in 422.2267(d)(2)(i) and 423.2267(d)(2)(i), to all new Enrollees at the time of enrollment and annually thereafter. The Contractor shall update such information no later than thirty (30) calendar days after being made aware of any change in information;

2.12.6.1.1.3. When there is a significant change to the network, send a notice to impacted Enrollees;

2.12.6.1.1.4. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. § 438.10(h);

2.12.6.1.1.5. Consistent with **Section 2.9** of this Contract, make a good faith effort to provide written notice of termination of a

contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date, irrespective of whether the termination was for cause or without cause, to all Members who regularly use the provider or pharmacy's services. If a contract termination involves a primary care professional, the Contractor shall notify Enrollees who are patients of that primary care professional;

2.12.6.1.1.6. Include written and oral offers of such Provider and Pharmacy Network directory in its outreach and orientation sessions for new Enrollees; and

2.12.6.1.1.7. Provide a notice to all Enrollees impacted by a termination or non-renewal of a hospital, community health center or community mental health center contract, chain pharmacy, or other primary care Provider site.

2.12.6.2. Content of Provider and Pharmacy Directory

2.12.6.2.1. The Provider and Pharmacy Directory shall include, at a minimum, the following information for all Network Providers as specified in **Section 1.109**:

2.12.6.2.1.1. The names, addresses, telephone numbers, website URL as appropriate, the total number of each type of provider, and any specialty and group affiliation as appropriate.

2.12.6.2.1.2. As applicable, Network Providers with training in and experience treating:

2.12.6.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness, and/or substance use disorder;

2.12.6.2.1.2.2. Homeless persons;

2.12.6.2.1.2.3. Persons who are Deaf or hard-of-hearing and blind or visually impaired;

2.12.6.2.1.2.4. Persons with cooccurring disorders; and

2.12.6.2.1.2.5. Other specialties.

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

2.12.6.2.1.4. Cultural capabilities, including, as applicable, whether the health care professional or non-facility-based Network Provider has completed cultural competence training;

2.12.6.2.1.5. 2.12.6.2.1.5. Telehealth capabilities, including, as applicable, whether the Network Providers offer covered services via telehealth;

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

2.12.6.2.1.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;

2.12.6.2.1.8. Whether the Network Provider is on a public transportation route;

2.12.6.2.1.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;

2.12.6.2.1.10. As applicable, whether the Network Provider has access to interpreter/translation services;

2.12.6.2.1.11. For Behavioral Health Providers, training in and experience treating trauma and substance use; and

2.12.6.2.1.12. The directory shall include a description of the process by which Enrollees select and change PCPs.

2.12.6.2.2. The directory shall include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

2.12.6.2.2.1. The names, addresses, telephone numbers of all current pharmacies; and

2.12.6.2.2.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line (as described in **Section 2.11**) for assistance in finding a convenient pharmacy, including one that is linguistically accessible.

2.13. Grievances and Appeals

2.13.1. General Requirements

2.13.1.1. The Contractor shall:

2.13.1.1.1. 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; and

2.13.1.1.2. Review the Grievance and Internal Appeals policies and procedures, 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, thirty (30) calendar days prior to the date of the amendment, unless otherwise specified by EOHHS.

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

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

2.13.1.2.2. A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.13.2** and **2.13.3** below; and

2.13.1.2.3. A means for expedited resolution of Internal Appeals, as further specified in **Section 2.13.4**, 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 2.13.4**, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

2.13.1.3. The Contractor shall accept Grievances filed either orally or in writing;

2.13.1.4. The Contractor shall create and maintain records of Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, appeals to the CMS Independent Review Entity, and all subsequent levels of External Appeals via both Medicare and Medicaid routes, using the health information system(s) specified in **Section 2.15.6**, to document:

2.13.1.4.1. The type and nature of each Grievance, Internal Appeal, BOH Appeal, and review by the CMS Independent Review Entity,

2.13.1.4.2. 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

2.13.1.4.3. What, if any, corrective action the Contractor took;

2.13.1.5. The Contractor shall report to EOHHS on Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity as described in **Appendix A** in a form and format specified by EOHHS, including but not limited to a summary, the number of Appeals per 1,000 Enrollees, and the number of Grievances per 1,000 Enrollees.

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

2.13.1.7. The Contractor shall provide Enrollees with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes in an accessible manner, as specified in **Section 2.13**,

2.13.1.8. The Contractor shall provide information about the Contractor's Grievance and Internal Appeal system to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor, including, at a minimum, information on the Grievance, Internal Appeal, and fair hearing procedures and timeframes. Such information shall include:

2.13.1.8.1. The right to file a Grievance or Internal Appeal;

2.13.1.8.2. The requirements and timeframes for filing a Grievance or Internal Appeal; and

2.13.1.8.3. The availability of assistance in the filing process.

2.13.1.9. The Contractor shall accept Grievances or internal Appeals and requests for determination or service authorization from the following individual or entities, who shall be considered parties to the case:

2.13.1.9.1. The Enrollee or their representative;

2.13.1.9.2. An assignee of the Enrollee (that is, a physician or other provider who has furnished or intends to furnish a service to the Enrollee and formally agrees to waive any right to payment from the Enrollee for that service), or any other provider or entity (other than the Contractor) who has an appealable interest in the proceeding;

2.13.1.9.3. The legal representative of a deceased Enrollee's estate; or

2.13.1.9.4. Any provider that furnishes, or intends to furnish, services to the Enrollee. If the provider requests that the benefits continue while the appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider shall obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee.

2.13.1.10. The timeframes and notice requirements set forth in this Section shall be the same for all Covered Services. Timeframe and notice requirements for Part B drugs are governed by and shall comply with 42 CFR 422.584(d)(1), 422.590(c), and 422.590(e)(2).

2.13.1.11. The Contractor's failure to adhere to the notice and timing requirements regarding service authorizations, determinations, and internal Appeals shall constitute an Adverse Action for the Enrollee such that:

2.13.1.11.1. For service authorizations and determinations, the Enrollee shall be entitled to file an Internal Appeal;

2.13.1.11.2. For Internal Appeals, the Enrollee shall be entitled to file a BOH Appeal or receive CMS Independent Review Entity pursuant to **Section 2.13.5.1**; and

2.13.1.11.3. Failure to adhere to the notice and timing requirements regarding service authorizations may result in intermediate sanctions as described in **Section 2.10.9.8**.

2.13.1.12. In the event that an Enrollee pursues an External Appeal in multiple forums and receives conflicting decisions, the Contractor is bound by and shall act in accordance with decisions most favorable to the Enrollee.

2.13.2. Grievances

2.13.2.1. The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and the receipt, timely resolution, and documentation by the Contractor of all Grievances which shall include, at a minimum, the following, in accordance with 42 CFR §§ 422.629 – 422.634, 438.210, and CFR Part 438, Subpart F. This includes:

2.13.2.1.1. Grievances and internal Appeals systems that meet the standards described in §422.629;

2.13.2.1.2. An integrated Grievance process that complies with §422.630; and

2.13.2.1.3. A process for effectuation of decisions consistent with §422.634.

2.13.2.2. General Requirements

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

2.13.2.2.1.1. A means for assessing and categorizing the nature and seriousness of a Grievance; and

2.13.2.2.1.2. A means for tracking how long the Contractor takes to dispose of or resolve Grievances and to provide notice of such disposition or resolution, as specified in **Sections 2.13.2.3** and **2.13.2.4** below.

2.13.2.2.2. The Contractor shall put in place a mechanism to accept Grievances at any time filed either orally or in writing.

2.13.2.2.3. The Contractor shall send a written acknowledgement of the receipt of any Grievance to Enrollees and, if an Appeals Representative filed the Grievance, to the Appeals Representative and the Enrollee within 1 business day of receipt by the Contractor.

2.13.2.3. Handling of Grievances

2.13.2.3.1. In handling Grievances, the Contractor shall:

2.13.2.3.1.1. Inform Enrollees of the Grievance procedures, as specified in **Section 2.5.3.2.1**;

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

2.13.2.3.1.3. Accept Grievances filed in accordance with **Section 2.13.1.3**;

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

2.13.2.3.1.5. Provide meaningful procedures for timely hearing and resolving Grievances between Enrollees and the Contractor or any other entity or individual through which the Contractor provides covered items and services,

2.13.2.3.1.6. Ensure that the individuals who make decisions on Grievances:

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

2.13.2.3.1.6.2. Take into account all comments, documents, records, and other information submitted by the Enrollee or the Appeal Representative.

2.13.2.3.1.7. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

2.13.2.3.1.7.1. Grievances regarding the denial of an Enrollee's request that an Internal Appeal be expedited, as specified in **Section 2.13.4.4.1.8**; and

2.13.2.3.1.7.2. Grievances regarding clinical issues.

2.13.2.4. Resolution and Notification of Grievances

2.13.2.4.1. The Contractor shall:

2.13.2.4.1.1. Dispose of each Grievance and provide notice of each Grievance disposition as expeditiously as the Enrollee's health condition requires. For the standard resolution of Grievances and notice to affected parties, no more than thirty (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, unless this timeframe is extended in accordance with **Section 2.13.2.2**;

2.13.2.4.1.2. Extend the timeframes in **Section 2.13.2.2** by up to fourteen (14) calendar days if:

2.13.2.4.1.2.1. The Enrollee or Appeal Representative requests the extension; or

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

2.13.2.4.1.2.2.1. The extension is in the Enrollee's interest; and

2.13.2.4.1.2.2.2. There is a need for additional information where:

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

2.13.2.4.1.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days;

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

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

2.13.2.4.1.2.3.2. Provide the Enrollee and Appeal Representative written notice of the reason for the delay within two (2) calendar days. Such notice shall include the reason for the extension of the timeframe.

2.13.2.4.1.2.3.3. Provide notice in accordance with this **Section 2.13.2** regarding the disposition of a Grievance as follows:

2.13.2.4.1.2.3.3.1. All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10.

2.13.2.5. External Grievances

2.13.2.5.1. The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor shall display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page as required by 42 C.F.R. § 422.504(b)(15)(ii). The Contractor shall inform Enrollees of the email address, postal address, or toll-free telephone number where an Enrollee Grievance may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.13.2.5.2. External Grievances filed with EOHHS shall be entered by the EOHHS contract manager into the CMS Complaints Tracking Module, which will be accessible to the Contractor.

2.13.3. Enrollee Appeals

2.13.3.1. Initial Appeals shall be filed with the Contractor, and may also be referred to as an Internal Appeal or a Request for Reconsideration.

2.13.3.2. Subsequent Appeals for Medicare A and B services (e.g., Medicare is the primary payer) shall be automatically forwarded to the Medicare Independent Review Entity (IRE) by the Contractor.

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

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

2.13.3.5. The Contractor shall utilize, and all Enrollees may access, the existing Medicare Part D Appeals Process. Consistent with existing rules, Part D Appeals will be automatically forwarded to the IRE if the Contractor misses the applicable adjudication timeframe. The Contractor shall maintain written records of all Appeal activities and notify CMS and MassHealth of all internal Appeals.

2.13.4. Internal Appeals

2.13.4.1. As a FIDE SNP, the Contractor's One Care Plan is an Applicable Integrated Plan. The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR 42 §§ 422.629 – 422.634, 438.210, and CFR Part 438, Subpart F for Applicable Integrated Plans. This includes:

2.13.4.1.1. A process for making Integrated Organization Determinations (referred to here as "determinations" or "service authorizations") consistent with §422.631;

2.13.4.1.2. Continuation of benefits ("Continuing Services") while an internal Appeal is pending consistent with §422.632;

2.13.4.1.3. A process for making integrated reconsiderations consistent with §422.633 (referred to here as “Internal Appeals”); and

2.13.4.1.4. A process for effectuation of decisions consistent with §422.634.

2.13.4.2. General Requirements

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

2.13.4.2.1.1. A means for assessing and categorizing the nature and seriousness of an Internal Appeal;

2.13.4.2.1.2. A means for tracking how long the Contractor takes to dispose of or resolve Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.13.4.3 and 2.13.4.4** below; and

2.13.4.2.1.3. A means for expedited resolution of Internal Appeals, as further specified in **Section 2.13.4.4.1.7**, 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 2.13.4.4**, could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain maximum function.

2.13.4.2.2. The Contractor shall put in a place a mechanism to accept Internal Appeals filed either orally or in writing within sixty (60) calendar days after receipt of the notice of Adverse Action specified in **Section 2.13.4.3**, provided that if an Internal Appeal is filed orally, the Contractor shall not require the Enrollee to submit a written, signed Internal Appeal form subsequent to the Enrollee’s oral request for an appeal and shall send the Enrollee or Appeal Representative an acknowledgement letter to confirm the facts and basis of the Internal Appeal. The date of receipt of the notice of Adverse Action is presumed to be five (5) calendar days after the date of the notice of Adverse Action, unless there is evidence to the contrary. For purposes of meeting the sixty (60) calendar day filing deadline, the Internal Appeal is considered as filed on the date it is received by the Contractor. Internal Appeals filed later than sixty (60) days from the notice of Adverse Action may be rejected as untimely unless the Enrollee shows good cause why the untimely Internal Appeal should be accepted.

2.13.4.2.3. The Contractor shall send a written acknowledgement of the receipt of any Internal Appeal to Enrollees and, if an Appeals Representative filed the Internal Appeal, to the Appeals Representative

and the Enrollee within one (1) business day of receipt by the Contractor.

2.13.4.2.4. The Contractor shall track whether an Internal Appeal was filed orally or in writing within sixty (60) calendar days from the notice of Adverse Action specified in **Section 2.13.4.3**.

2.13.4.2.5. The Contractor shall track and report to EOHHS in the form and format specified by EOHHS the status, dates of various actions, and timeliness of all Appeals from receipt of the Internal Appeal through to the most advanced stage of the Appeal, including External Appeals stages when applicable, as well as the decisions at all levels of the Appeal process, notifications for Appeals at all levels, the status of Continuing Services requests and implementation, and the resolution of the Appeal, including implementation of the Appeal decision for the Enrollee.

2.13.4.2.6. When making internal Appeal decisions, the Contractor shall apply the definition of Medical Necessity in this Contract and shall apply the cumulative Medicare and MassHealth requirements for Covered Services for services that overlap between payers, including any resulting expanded amount, duration, and scope, as well as frequency and type criteria.

2.13.4.2.7. The Contractor shall provide Continuing Services for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes in 42 C.F.R. § 438.420. This means that such benefits shall continue to be provided by providers to Enrollees and that the Contractors shall continue to pay providers for providing such services or benefits pending an internal Appeal. The Contractor may not recover the cost of services furnished to Enrollees under this Section without prior EOHHS approval of such a policy and provision of advance notice to Enrollees.

2.13.4.3. Resolution and notification for Internal Appeals

2.13.4.3.1. The Contractor shall make internal Appeals decisions as expeditiously as the Enrollee's health condition requires but no later than the timeframes established in this **Section 2.13.4.3** and in accordance with § 422.633(f). Integrated reconsidered determinations regarding Part B drugs shall comply with the timelines governing Part B drugs established in §§ 422.584(d)(1) and 422.590(c) and (e)(2).

2.13.4.3.1.1. Standard Internal Appeal Decisions. The Contractor shall resolve internal Appeals as expeditiously as the enrollee's health condition requires but no later than thirty (30) calendar days from the date of receipt of the request for the

internal Appeal. This timeframe may be extended as described in **Section 2.13.4.3.1.3** below.

2.13.4.3.1.2. Expedited Internal Appeal Decisions. The Contractor shall resolve expedited integrated reconsiderations as expeditiously as the enrollee's health condition requires but no later than within seventy-two (72) hours of receipt of the Internal Appeals. This timeframe may be extended as described in **Section 2.13.4.3.1.3** below. In addition to the written notice required as described in **Section 2.13.4.4** below, the Contractor shall make reasonable efforts to provide prompt oral notice of the expedited decision to the Enrollee.

2.13.4.3.1.3. Extensions. The Contractor may extend the timeframe for resolving any integrated reconsideration other than those concerning Part B drugs by fourteen (14) calendar days if:

2.13.4.3.1.3.1. The Enrollee requests the extension; or

2.13.4.3.1.3.2. The Contractor can show that:

2.13.4.3.1.3.2.1. The extension is in the Enrollee’s interest; and

2.13.4.3.1.3.2.2. There is need for additional information and a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

2.13.4.3.1.3.3. If the Contractor extends the timeframe for resolving the internal Appeal, it shall make reasonable efforts to give the Enrollee prompt oral notice of the delay, and give the Enrollee written notice within two (2) calendar days of making the decision to extend the timeframe to resolve the internal Appeal. The notice shall include the reason for the delay and inform the Enrollee of the right to file an expedited grievance if they disagree with the decision to grant an extension.

2.13.4.4. Notice of Adverse Action/Coverage Decision Letter

2.13.4.4.1. In accordance with 42 CFR §438.210, the Contractor shall provide a Coverage Decision Letter to the requesting provider and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.13.4.4.2. As a FIDE SNP, the Contractor shall complete and issue a Coverage Decision Letter to Enrollees, when, as a result of an Integrated Organization Determination under 42 CFR §422.631, it reduces, stops, suspends, or denies, in whole, or in part, a request for a service or item (including a Medicare Part B drug) or a request for a payment of a service or item (including a Medicare Part B drug) the Enrollee has already received.

2.13.4.4.3. The Contractor shall use the Coverage Decision Letter in place of the Adverse Action or the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS-10003).

2.13.4.4.4. The Contractor shall not send this letter when the request for a service or item is fully covered by the Contractor's SCO Plan, either under the Medicare or Medicaid benefit.

2.13.4.4.5. This letter shall not be used for Medicare Part D denials. The provisions of this **Section 2.13.4.3** do not apply to Medicare Part D denials. For Part D denials, the Contractor shall use form CMS-10146, Notice of Denial of Medicare Prescription Drug Coverage.

2.13.4.4.6. The Coverage Decision Letter shall meet the language and format requirements specified in **Section 2.10.9.7**.

2.13.4.4.7. At a minimum, and in accordance with 42 CFR §422.631(d)(1), the Coverage Decision Letter shall explain the following Enrollee rights:

2.13.4.4.7.1. 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;

2.13.4.4.7.2. The Enrollee's right to file an Internal Appeal (also referred to as an "integrated reconsideration") 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;

2.13.4.4.7.3. That the Contractor shall provide the Enrollee Continuing Services, if applicable, pending resolution of the review of an Internal Appeal if the Enrollee submits the request for the review within ten (10) days of the Adverse Action; and

2.13.4.4.7.4. That the Contractor shall provide the Enrollee Continuing Services, if applicable, pending resolution of a BOH Appeal if the Enrollee submits the request for the BOH Appeal within

ten (10) days of receipt of notice of the Final Internal Appeal Decision, unless the Enrollee specifically indicates that they do not want to receive Continuing Services.

2.13.4.4.8. At a minimum, and in accordance with 42 CFR §422.631(d)(1), the Coverage Decision Letter shall include the following:

2.13.4.4.8.1. Key contact information, including the health plan name, the plan customer service phone number, the Ombudsman phone number, and any other applicable program phone number;

2.13.4.4.8.2. The applicable integrated plan's determination;

2.13.4.4.8.3. The date the determination was made;

2.13.4.4.8.4. The date the determination will take effect;

2.13.4.4.8.5. The reasons for the determination;

2.13.4.4.8.6. The enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf;

2.13.4.4.8.7. Procedures for exercising enrollee's rights to an integrated reconsideration;

2.13.4.4.8.8. Circumstances under which expedited resolution is available and how to request it; and

2.13.4.4.8.9. If applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

2.13.4.5. Timing of Notice

2.13.4.5.1. In accordance with 42 CFR § 422.631(2), the Contractor shall mail the coverage decision letter within the following timeframes:

2.13.4.5.1.1. In cases where a previously approved service is being reduced, suspended, or terminated, at least fifteen (15) calendar days prior to the date of action, including: ten (10) calendar days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective); and an additional five (5) calendar days for mailing.

2.13.4.5.1.1.1. In circumstances where an exception is permitted under 42 CFR §§ 431.213 and 431.214, and in

accordance with 42 CFR 431.214, the period of advance notice may be shortened to five (5) calendar days before the Date of Action if the Contractor has facts indicating that action shall be taken because of probable fraud by the Enrollee and the facts have been verified, if possible, through secondary sources.

2.13.4.5.1.2. For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.10.9**, as expeditiously as the Enrollee's health condition requires but no later than seven (7) calendar days following receipt of the service request, unless the timeframe is extended up to fourteen (14) additional calendar days.

2.13.4.5.1.2.1. The Contractor may extend the timeframe for a standard or expedited Integrated Organization Determination by up to fourteen (14) calendar days only if:

2.13.4.5.1.2.1.1. The Provider, Enrollee, or Appeal Representative requests the extension; or

2.13.4.5.1.2.1.2. 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:

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

2.13.4.5.1.2.1.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.13.4.5.1.2.2. If the Contractor extends the timeframe, it shall:

2.13.4.5.1.2.2.1. Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's health condition requires but no later than within two (2) calendar days of making the decision to extend the timeframe, and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

2.13.4.5.1.2.2.2. Issue and carry out its determination as expeditiously as the Enrollee's health condition

requires and no later than the date the extension expires.

2.13.4.5.1.3. 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:

2.13.4.5.1.3.1. Failure to follow prior authorization procedures;

2.13.4.5.1.3.2. Failure to follow referral rules; and

2.13.4.5.1.3.3. Failure to file a timely claim.

2.13.4.5.1.4. For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.10.9**, and for expedited requests for determinations, as expeditiously as the Enrollee's health requires but no later than seventy-two (72) hours after the receipt of the expedited request for service.

2.13.4.5.1.4.1. If the Contractor denies the request for expedited authorization or determination, the Contractor shall:

2.13.4.5.1.4.1.1. Automatically transfer the request to the standard timeframe and make the determination within seven (7) calendar days as set forth in **Section 2.13.4.5.1.2**. The timeframe begins with the day the Contractor receives the request for expedited determination.

2.13.4.5.1.4.1.2. Give the Enrollee prompt oral notice of the denial and transfer and subsequently deliver, within three (3) calendar days, a written notice that:

2.13.4.5.1.4.1.2.1. Explains that the Contractor will process the request using the seven (7) calendar day timeframe for standard determinations;

2.13.4.5.1.4.1.2.2. Informs the Enrollee of the right to file an expedited Grievance if the Enrollee disagrees with the decision not to expedite;

2.13.4.5.1.4.1.2.3. Informs the Enrollee of the right to resubmit a request for an expedited

determination with any physician's support; and

2.13.4.5.1.4.1.2.4. Provides instructions about the Grievance process and its timeframes.

2.13.4.5.1.4.2. If the Contractor must receive medical information from non-contracted providers, the Contractor shall request the necessary information from the non-contracted provider within twenty-four (24) hours of the initial request for an expedited determination. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Contractor in meeting the required timeframe. Regardless of whether the Contractor must request information from non-contracted providers, the Contractor is responsible for meeting the timeframe and notice requirements of this Section.

2.13.4.5.1.5. The Contractor may extend the timeframe for an expedited Service Authorization Request up to fourteen (14) additional calendar days. Such extension shall be implemented as follows:

2.13.4.5.1.5.1. The extension shall only be allowed if:

2.13.4.5.1.5.1.1. The Provider, Enrollee or Appeal Representative requests the extension; or

2.13.4.5.1.5.1.2. The Contractor can justify (to EOHHS, upon request) that the extension is in the Enrollee's interest; and that there is a need for additional information where:

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

2.13.4.5.1.5.1.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.13.4.5.1.5.2. If the Contractor extends the timeframe, it shall do the following:

2.13.4.5.1.5.2.1. Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's

health condition requires, but no later than the expiration of the extension, and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

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

2.13.4.5.1.6. For standard or expedited service authorization decisions not reached within the timeframes specified in **Section 2.10.9**, whichever is applicable, on the day that such timeframes expire.

2.13.4.5.1.7. When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 2.10.2**, within one (1) business day upon notification by the Enrollee or Provider that one of the access standards in **Section 2.10.2** was not met.

2.13.5. External Appeals

2.13.5.1. CMS Independent Review Entity

2.13.5.1.1. 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 shall, in accordance with CMS guidelines, prepare a written explanation and automatically forward the case file to the CMS Independent Review Entity, contracted by CMS, for a new and impartial review within the following timeframes:

2.13.5.1.1.1. For standard internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than thirty (30) calendar days from the date it received the internal Appeal (or the end of an extension pursuant to **Section 2.13.4**); and

2.13.5.1.1.2. For expedited internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than twenty-four (24) hours of its affirmation (or the end of an extension) pursuant to **Section 2.13.4**.

2.13.5.1.2. The Contractor shall make reasonable and diligent efforts to assist in gathering and forwarding information to the CMS Independent Review Entity.

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

2.13.5.1.4. If the CMS Independent Review Entity decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor shall authorize the service under dispute within seventy-two (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 fourteen (14) calendar days from the date of the notice.

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

2.13.5.1.6. If the CMS Independent Review Entity decides in the Enrollee's favor, the Contractor shall authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (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.

2.13.5.1.7. 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 shall comply with any requests for information or participation from such further Appeal entities.

2.13.5.2. Board of Hearings (BOH)

2.13.5.2.1. All Medicaid Covered Services, Additional Community-Based services (if applicable), and Flexible Benefits may be appealed to the MassHealth BOH, including concurrently for appeals forwarded to the Medicare IRE.

2.13.5.2.2. If, on internal appeal, the Contractor does not decide fully in the Enrollee's favor, and the Appeal concerns a Medicaid covered service, the Contractor shall:

2.13.5.2.2.1. 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:

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

2.13.5.2.2.1.2. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fail to satisfy applicable notice requirements.

2.13.5.2.2.2. Include with any notice following the resolution of a standard Internal Appeal or an expedited Internal Appeal, as specified in **Section 2.13.4**, 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

2.13.5.2.2.3. Notify Enrollees that:

2.13.5.2.2.3.1. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Enrollee specifically indicates that they do not want to receive Continuing Services; and

2.13.5.2.2.3.2. 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 time limits, as specified in 130 CMR 610.015(B)(7), specifically:

2.13.5.2.2.3.2.1. 120 days after the Enrollee's receipt of the Contractor's Final Internal Appeal Decision where the Contractor has reached a decision wholly or partially adverse to the Enrollee, provided, however, that if the Contractor did not resolve the Enrollee's Internal Appeal within the time frames specified in this Contract and described by 130 CMR 508.010(A), one hundred and twenty (120) days after the date on which the time frame for resolving that Internal Appeal has expired; and

2.13.5.2.2.3.2.2. For all BOH Appeals in which the Enrollee wants Continuing Services that are the subject of the BOH Appeal, such request shall be submitted within ten (10) calendar days after the notice

following the Internal Appeal, as specified in **Section 2.13.4.2.3**.

2.13.5.2.2.3.3. A BOH decision may be subject to judicial review pursuant to 130 CMR 610.092.

2.13.5.3. If the Contractor or the Enrollee disagrees with the BOH decision, further levels of Appeal are available, including judicial review of the decision under M.G.L. c. 30A. At the direction of EOHHS, the Contractor shall be a party to the Board of Hearings Appeal and any subsequent actions and further levels on the Appeal, along with the Enrollee and their representative or the representative of a deceased Enrollee's estate. The Contractor shall comply with any final decision upon judicial review.

2.13.5.4. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

2.13.6. Additional Requirements

2.13.6.1. The Contractor shall:

2.13.6.1.1. For all Final Internal Appeal Decisions upholding an Adverse Action, in whole or in part, the Contractor shall provide EOHHS upon request, within one business day of issuing the decision, with a copy of the decision sent to the 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. EOHHS may consult with other state agencies in its review of the Contractor's decision;

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

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

2.13.6.1.4. 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;

2.13.6.1.5. 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 five (5) business days prior to the date of the hearing, or if the BOH Appeal is expedited, within one (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;

2.13.6.1.6. Comply with and implement the decisions of the BOH;

2.13.6.1.7. 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

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

2.13.6.1.8.1. Determine whether each Enrollee who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 2.13.4**;

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

2.13.6.1.8.3. 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;

2.13.6.1.8.4. 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 they do not want to receive Continuing Service;

2.13.6.1.8.5. 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;

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

2.13.6.1.8.7. Ensure that appropriate Contractor staff attend BOH hearings;

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

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

2.13.6.1.8.10. Ensure that the Contractor implements BOH decisions upon receipt;

2.13.6.1.8.11. Report to EOHHS within thirty (30) calendar days of receipt of the BOH decision that such decision was implemented;

2.13.6.1.8.12. Coordinate with the BOH, as directed by EOHHS; and

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

2.13.6.1.9. Provide information about the Contractor's grievances and appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities enter into a contract; and

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

2.13.6.1.10.1. A general description of the reason for the Appeal or Grievance;

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

2.13.6.1.10.3. Resolution of the Appeal or Grievance, and date of resolution; and

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

2.13.7. Continuing Services

2.13.7.1. For an Appeal involving the reduction, suspension, or termination of a previously authorized service, the Contractor shall:

2.13.7.1.1. Comply with the provisions of 42 CFR 422.632 and 42 CFR 438.420 and, in addition:

2.13.7.1.2. Provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Enrollee specifically indicates that they do not want to receive Continuing Services;

2.13.7.1.3. Provide such Continuing Services until one of the following occurs:

2.13.7.1.3.1. The Enrollee withdraws the Internal Appeal or BOH Appeal; or

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

2.13.7.1.4. Pay for such Continuing Services, regardless of whether the Internal Appeal or BOH decision reverses or upholds an Adverse Action to deny, limit, or delay services;

2.13.7.1.5. Not pursue recovery for costs of such Continuing Services when they are:

2.13.7.1.5.1. Furnished by the Contractor pending the Internal Appeal; or

2.13.7.1.5.2. Furnished by the Contractor after the Internal Appeal while the BOH Appeal is pending, unless the Contractor has received prior EOHHS approval to pursue such recovery and has provided advance notice to Enrollees.

2.13.7.1.6. 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 seventy-two (72) hours from the date it receives notice reversing the determination.

2.13.8. Discharge Appeals

2.13.8.1. Hospital Discharge Appeals

2.13.8.1.1. When a Dual Eligible Enrollee is being discharged from the hospital, the Contractor shall assure that the Enrollee receives a written notice of explanation required by 42 CFR §§ 422.620-622.

2.13.8.1.2. The Enrollee has the right to request a review of any hospital discharge notice by a Quality Improvement Organization (QIO). The notice includes information on filing the QIO Appeal. Such a request

shall be made by noon of the first workday after the receipt of the notice.

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

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

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

2.13.8.1.6. If the QIO overturns the Contractor's decision, the Contractor shall pay for the remainder of the hospital stay.

2.13.8.2. Other Discharge Appeals

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

2.14. Quality Management

2.14.1. Quality Improvement (QI) Program

2.14.1.1. The Contractor shall deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, maintain their independence in the community, and maintain/improve their quality of life. Quality care refers to:

2.14.1.1.1. Clinical quality of physical health care, including primary and specialty care;

2.14.1.1.2. Clinical quality of mental health care focused on recovery, resiliency and rehabilitation;

2.14.1.1.3. Clinical quality of substance use disorder treatment focused on intervention, treatment, recovery, resiliency and rehabilitation;

2.14.1.1.4. Quality of LTSS;

2.14.1.1.5. Quality of oral health care;

2.14.1.1.6. Adequate access and availability to primary, mental health care, substance use disorder treatment, specialty health care, oral health care, pharmacy, and LTSS providers and services;

2.14.1.1.7. Continuity and coordination of care across all care and service settings, and for transitions in care; and

2.14.1.1.8. Enrollee experience with respect to clinical quality, access, and availability of high quality, coordinated, culturally and linguistically competent health care and services, inclusive of LTSS across the care continuum, as well as continuity and coordination of care.

2.14.1.2. The Contractor shall 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:

2.14.1.2.1. Quantitative and qualitative data collection and data- driven decision- making;

2.14.1.2.2. 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;

2.14.1.2.3. Feedback provided by Enrollees and Network Providers in the design, planning, and implementation of its Continuous Quality Improvement activities; and

2.14.1.2.4. Issues identified by the Contractor and/or EOHHS.

2.14.1.3. The Contractor shall ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health Services, community- based services, and LTSS.

2.14.2. QI Program Structure

2.14.2.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Measurement and Improvement, and shall meet the

quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2.14.2.2. The Contractor shall:

2.14.2.2.1. Establish a clearly defined set of QI functions and responsibilities that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion on Quality Improvement initiatives in a competent and timely manner;

2.14.2.2.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, Continuous Quality Improvement to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.14.2.2.3. Establish internal processes to ensure that the QM activities for Physical Health Services, Behavioral Health Services, Specialty, community-based services, and LTSS reflect utilization across the Network and include all of the activities in this **Section 2.14** of this Contract and, in addition, the following elements:

2.14.2.2.3.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS) and non-HEDIS quality measure results, including Member experience data, in designing QI activities;

2.14.2.2.3.2. A process to collect race, ethnicity, language and other demographic data elements (e.g., disability status, sexual orientation, gender identity, health-related social needs) to support stratification of HEDIS and non-HEDIS quality measure results to identify disparities and address Health Equity;

2.14.2.2.3.3. A process to utilize HEDIS and non-HEDIS quality measure performance data, including as stratified for the identification of health inequities and to inform design of QM/QI activities to address Health Equity;

2.14.2.2.3.4. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used, which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to EOHHS upon request;

2.14.2.2.3.5. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's Plan. The Contractor shall submit the survey plan to EOHHS for approval and shall submit the results of the survey to EOHHS;

2.14.2.2.3.6. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

2.14.2.2.3.7. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in the Consumer Advisory Board; and

2.14.2.2.3.8. In collaboration with and as further directed by EOHHS, develop a customized medical record review process to monitor the assessment for and provision of LTSS, including the assessment of care between settings and a comparison of services and supports received with those in the Enrollee's Individualized Care Plan.

2.14.2.2.4. Have in place, and submit to EOHHS annually, a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Changes from a prior year shall be clear in the annual submission. Such description shall:

2.14.2.2.4.1. Address all aspects of health care quality improvement including but not limited to specific reference to mental health care, substance use disorder treatment, oral health and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care;

2.14.2.2.4.2. Address Health Related Social Needs and Health Equity;

2.14.2.2.4.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems;

2.14.2.2.4.4. Address the roles of designated physician(s), behavioral health clinician(s), community-based service providers, and LTSS providers with respect to the QI program; and

2.14.2.2.4.5. 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.

2.14.2.2.5. Submit to EOHHS an annual QI Work Plan that broadly describes the Contractor's annual QI activities under its QI program, in accordance with **Appendix B**, and that includes the following components or other components as directed by EOHHS:

2.14.2.2.5.1. Planned clinical and non-clinical initiatives;

2.14.2.2.5.2. The objectives for planned clinical and non-clinical initiatives;

2.14.2.2.5.3. The short and long-term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.14.2.2.5.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.14.2.2.5.5. Any issues identified by the Contractor, EOHHS, Enrollees, and providers, and how those issues will be tracked and resolved over time; and

2.14.2.2.5.6. The evaluations of clinical and non-clinical initiatives, including Provider profiling activities as described in **Section 2.9.9** and the results of Network Provider satisfaction surveys as described in **Section 2.14.2.2.3.5**.

2.14.2.3. Process for correcting deficiencies.

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

2.14.2.3.2. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g., education, training, and experience) for employees who will be responsible for QM. QI staff shall include:

2.14.2.3.2.1. At least one (1) designated physician, who shall be a medical director or associate medical director, at least one (1) designated behavioral health clinician, and a professional with expertise in the assessment and delivery of Long-term

Services and Supports with substantial involvement in the QI program;

2.14.2.3.2.2. A qualified individual to serve as the QI Director who will be directly accountable to the Contractor's contract manager or equivalent position and has direct access to the Plan's executive leadership team. This individual shall be responsible for:

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

2.14.2.3.2.2.2. Maintaining an active role in the Contractor's overall QI structure;

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

2.14.2.3.2.2.3.1. Physical and behavioral health care;

2.14.2.3.2.2.3.2. Pharmacy management;

2.14.2.3.2.2.3.3. Care management;

2.14.2.3.2.2.3.4. LTSS;

2.14.2.3.2.2.3.5. Financial;

2.14.2.3.2.2.3.6. Statistical/analytical;

2.14.2.3.2.2.3.7. Information systems;

2.14.2.3.2.2.3.8. Marketing, publications;

2.14.2.3.2.2.3.9. Enrollment; and

2.14.2.3.2.2.3.10. Operations management.

2.14.2.3.3. Actively participating in, or assigning staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by EOHHS, or an EOHHS Contractor, that may be attended by representatives of EOHHS, an EOHHS Contractor, EOHHS-contracted SCO Plans, and other entities, as appropriate; and

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

2.14.3. QI Activities

2.14.3.1. Performance Measurement and Improvement Projects

2.14.3.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 CFR 438.242(a) and (b).

2.14.3.1.2. As further specified by EOHHS, the Contractor shall report the results of, or submit to EOHHS data which enables EOHHS to calculate, the Performance Measures set forth in **Appendix B**, in accordance with 42 CFR 438.330 (c). Such Performance Measures may include those specified by CMS in accordance with 42 CFR 438.330 (a)(2). At the direction of EOHHS, the Contractor shall support health Equity initiatives through the stratification of select performance measure or the submission of data elements, which may include, but shall not be limited to, factors such as race, ethnicity, language, disability, status, age, sexual orientation, gender identity, and Health Related Social Needs.

2.14.3.1.3. EOHHS may, at its discretion and at any time, identify certain thresholds for Performance Measures or stratified measures which the Contractor shall meet, and the Contractor shall work with EOHHS on such thresholds upon EOHHS's request. If EOHHS requests further information about the Contractor's performance on such measures, the Contractor shall discuss such performance, and upon request, provide EOHHS with an analysis explaining the Contractor's performance.

2.14.3.1.4. Upon request, the Contractor shall submit an improvement plan to EOHHS. The Contractor shall implement, as approved by EOHHS, a concrete plan for improving its performance. The Contractor shall demonstrate how the contractor will utilize Performance Measure results or stratified measures in designing ongoing QM/QI initiatives to measure, monitor, and improve quality and Health Equity.

2.14.3.2. Member Experience Surveys

2.14.3.2.1. The Contractor shall contribute to and participate in all EOHHS Member experience survey activities, as directed by EOHHS.

2.14.3.2.2. In accordance with 42 CFR 438.330(c), the Contractor shall administer and submit annually to EOHHS the results from the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (MA PD CAHPS) conducted by an approved CAHPS vendor, including the results of any Supplemental Questions as required by EOHHS, as specified in **Appendix A**.

2.14.3.2.3. As directed by EOHHS, the Contractor shall conduct the HCBS Experience survey for Enrollees utilizing LTSS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed.

2.14.3.2.4. As directed by EOHHS, the Contractor shall contribute to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS.

2.14.3.2.5. The Contractor shall demonstrate best efforts to utilize CAHPS survey results in designing QI initiatives.

2.14.3.2.6. All measurement activities and reporting shall be conducted such that the resulting data and information is specific and exclusive to the population served under this Contract.

2.14.3.3. Quality Improvement Project Requirements

2.14.3.3.1. The Contractor shall implement and adhere to all processes relating to the Quality Improvement Project requirements, as directed by EOHHS and as specified in **Appendix L**, as follows:

2.14.3.3.1.1. In accordance with 42 C.F.R. §438.330 (d), collect information and data in accordance with Quality Improvement project requirements for its Enrollees;

2.14.3.3.1.2. Implement well-designed, innovative, targeted, and measurable quality improvement interventions, in a culturally and linguistically competent manner, to achieve objectives as specified in **Appendix L**;

2.14.3.3.1.3. Evaluate the effectiveness of quality improvement interventions incorporating specified targets and measures for performance;

2.14.3.3.1.4. Plan and initiate processes to sustain achievements and continue improvements;

2.14.3.3.1.5. Submit to EOHHS comprehensive written reports, using the format, submission guidelines, and frequency specified by EOHHS, and in accordance with **Appendix A**. Such reports shall include information regarding progress on Quality Improvement goals, barriers encountered, and new knowledge gained. As directed by EOHHS, the Contractor shall present this information to EOHHS at the end of the quality improvement project cycle as determined; and

2.14.3.3.1.6. Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare pursuant to 42 C.F.R §§ 441.302 and 441.730(a)) that are based, at a minimum, on the requirements on the State for HCBS waiver programs under 42 C.F.R. § 441.302(h).

2.14.4. External Quality Review (EQR) Activities

2.14.4.1. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities, in accordance with 42 C.F.R. Part 438.358. EQR Activities shall include, but are not limited to:

2.14.4.1.1. Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;

2.14.4.1.2. Annual validation of performance improvement projects required by EOHHS;

2.14.4.1.3. At least once every three years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees; and

2.14.4.1.4. Annual validation of network adequacy during the preceding twelve (12) months.

2.14.4.2. The Contractor shall take all steps necessary to support the EQRO in conducting EQR Activities including, but not limited to:

2.14.4.2.1. Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

2.14.4.2.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.14.4.2.1.2. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO and EOHHS staff in a timely manner;

2.14.4.2.1.3. Serve as the liaison to the EQRO, EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

2.14.4.2.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR Activity and as requested by the EQRO or EOHHS.

2.14.4.2.2. Maintaining data and other documentation necessary for completion of EQR Activities specified above for a minimum of seven (7) years;

2.14.4.2.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or EOHHS;

2.14.4.2.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;

2.14.4.2.5. Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQRO and sharing outcomes and results of such activities with the EQRO, and EOHHS in subsequent years; and

2.14.4.2.6. Participating in any other activities deemed necessary by the EQRO and approved by EOHHS.

2.14.5. QI for Utilization Management Activities

2.14.5.1. The Contractor shall utilize QI to ensure that it maintains a well-structured utilization management (UM) program that supports the application of fair, impartial and consistent UM determinations and shall address findings regarding underutilization and overutilization of services. The QI activities for the UM Program shall include:

2.14.5.1.1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;

2.14.5.1.2. At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one designated Behavioral Health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the

assessment and delivery of Long-term Services and Supports representative of the Contractor or Material Subcontractor, with substantial involvement in the UM program; and

2.14.5.1.3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

2.14.6. Clinical Practice Guidelines

2.14.6.1. The Contractor shall:

2.14.6.1.1. Adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

2.14.6.1.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field, or professionals with expertise in the assessment and delivery of long- term services and supports in the relevant field, community- based support services or the Contractor's approved behavioral health performance specifications and Clinical Criteria;

2.14.6.1.1.2. Consider the needs of Enrollees;

2.14.6.1.1.3. Stem from recognized organizations that develop or promulgate evidence- based clinical practice guidelines, or are developed with involvement of board- certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of long- term services and supports;

2.14.6.1.1.4. Do not contradict existing Massachusetts promulgated guidelines as published by the Department of Public Health, the Department of Mental Health, or other State agencies;

2.14.6.1.1.5. Prior to adoption, have been reviewed by the Contractor's Medical Director, as well as other SCO Plan practitioners and Network Providers, as appropriate; and

2.14.6.1.1.6. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.14.6.1.2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable

clinical evidence, or consensus of health care and LTSS professionals and providers;

2.14.6.1.3. For guidelines that have been in effect two years or longer, the Contractor shall document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly,

2.14.6.1.4. Disseminate, in a timely manner, the clinical guidelines to all new Network Providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's Web site. The Contractor shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made;

2.14.6.1.5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across Utilization Management decisions and Enrollee education; and

2.14.6.1.6. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

2.14.7. QI Workgroups

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

2.14.7.2. Healthcare Plan Effectiveness Data and Information Set

2.14.7.2.1. The Contractor shall collect annual HEDIS data and contribute to all HEDIS related processes, as directed by EOHHS, and as follows:

2.14.7.2.1.1. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports;

2.14.7.2.1.2. Collect and submit to EOHHS, annually, full Interactive Data Submission System (IDSS) for HEDIS measures as reported to NCQA for monitoring purposes that may be publicly reported as determined by EOHHS;

2.14.7.2.1.3. Upon request, submit to EOHHS Contractor-stratified rates for selected HEDIS measures specified by EOHHS,

Stratification of measures may include age, race, ethnicity, language, disability status, sexual orientation, gender identity, health related social needs, or other demographic elements as available;

2.14.7.2.1.4. Contribute to EOHHS's data quality assurance processes, which shall include but not limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS;

2.14.7.2.1.5. If directed by EOHHS, contribute to EOHHS processes regarding the individual and aggregate performance of MassHealth contract plans with respect to selected HEDIS measures; and

2.14.7.2.1.6. Contribute to EOHHS processes culminating in the publication of any technical or other reports by EHHS related to selected HEDIS measures.

2.14.7.3. EOHHS-Directed Performance Incentive Program

2.14.7.3.1. The Contractor shall meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in **Section 4.7.2**. In order to receive any withhold payments, the Contractor shall comply with all EOHHS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.14.7.4. Enrollee Incentives

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

2.14.7.4.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2.14.7.4.1.2. Ensure that the nominal value of Enrollee incentives do not exceed one hundred dollars ($100); and

2.14.7.4.1.3. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with State and federal laws.

2.14.8. Behavioral Health Services Outcomes

2.14.8.1. The Contractor shall require Behavioral Health Providers to measure and collect clinical outcomes data, to incorporate that data in treatment planning and within the medical record, and to make clinical outcomes data available to the Contractor, upon request.

2.14.8.2. The Contractor's Behavioral Health Provider contracts shall require the provider to make available outcomes data for quality management and Network Management purposes.

2.14.8.3. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by EOHHS, the Contractor shall collaborate with Behavioral Health Providers to develop outcome measures that are specific to each Behavioral Health Service type. Such outcome measures may include:

2.14.8.3.1. Recidivism;

2.14.8.3.2. Adverse occurrences;

2.14.8.3.3. Treatment drop-out;

2.14.8.3.4. Length of time between admissions; and

2.14.8.3.5. Treatment goals achieved.

2.14.9. LTSS Measurement Development

2.14.9.1. The Contractor shall participate with EOHHS in the ongoing development and adoption of quality measures related to delivery of Long-term Services and Supports.

2.14.10. External Research Projects

2.14.10.1. The Contractor may participate in external research projects that are pre-approved by EOHHS, at the discretion of the Contractor, through which the Contractor supplies Enrollee data to an external individual or entity. The Contractor shall:

2.14.10.1.1. As a covered entity (CE), follow HIPAA privacy and security rules with respect to Protected Health Information (PHI), in accordance with 45 CFR 164.501 and **Section 5.2** of this contract;

2.14.10.1.2. Submit to EOHHS, at the direction of and in a form and format specified by EOHHS, an application to participate in an external study and application for release of MassHealth data, as appropriate, for prior review and approval; and

2.14.10.1.3. Submit to EOHHS, the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

2.14.11. External Audit/Accreditation Results

2.14.11.1. The Contractor shall inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation and authorize the accrediting entity to submit to EOHHS, at the direction of EOHHS, a copy of its most recent accreditation review including the expiration date, the recommended action or improvements, corrective action plans, and summaries of findings if any, in addition to the results of other quality related external audits, if any.

2.14.12. Health Information System

2.14.12.1. The Contractor shall maintain a health information system or systems consistent with the requirements established in the Contract, the objectives of 42 C.F.R. § 438.242, and that supports all aspects of the QI Program.

2.14.13. Health Equity Strategic Plan and Reporting

2.14.13.1. The Contractor shall create, monitor, and update a Five-year Health Equity Strategic Plan, which shall be submitted to EOHHS for review and approval as follows:

2.14.13.1.1. In accordance with **Appendix A**, the Five-year Health Equity Strategic Plan shall be submitted to EOHHS for approval one (1) year after the Contract Operational Start Date.

2.14.13.1.2. Following the submission of the Five-year Health Equity Strategic Plan, the Contractor shall submit modifications annually for EOHHS approval. In addition, the Contractor shall submit evaluations annually, demonstrating how the plan goals, objectives, and activities are progressing, as described in **Section 2.14.13.2**.

2.14.13.1.3. All submissions of the Five-year Health Equity Strategic Plan shall be limited to a maximum of ten (10) pages.

2.14.13.2. The Contractor shall include in the plan an executive summary, in a form and format that is clear and concise, and includes an overview of all the key Sections of the plan, including but not limited to:

2.14.13.2.1. The Identification of Goals, Objectives, and Activities:

2.14.13.2.1.1. The Contractor shall develop goals, objectives, and activities that are specific to advancing Health Equity-related

initiatives and reducing health-related disparities for each year of the Contract for the entire five (5) year Contract;

2.14.13.2.1.2. Goals shall be broad and overarching statements that describe what the Five-year Health Equity Plan is trying to achieve. Goals are not necessarily measurable. Rather, each goal will have specific objectives that are measurable. An example of a goal may be, “To deliver high-quality care that continuously reduces inequities in SCO plans.”

2.14.13.2.1.3. Objectives are specific measures for achieving a goal. Objectives shall be specific, measurable, achievable, realistic, and time-bound (SMART). The objectives shall show what the plan hopes to improve (in terms of outcomes). An example of an object may be “To reduce the prevalence of smoking among male adults age sixty-five (65) years and above from 36% to 20% in 2027.”

2.14.13.2.1.4. Activities shall be specific actions or interventions that are required to achieve objectives. An example of an activity may be “To train all Providers in the Contractor’s Provider Network in how to establish a culture of equity by the end of year two (2) of the Five-year Health Equity Strategic Plan.”

2.14.13.2.2. Evidence-based Interventions: The Contractor's planned approaches to developing and implementing evidence-based interventions, including how it will:

2.14.13.2.2.1. Inform the development of interventions through quality performance data collection and subsequent analysis. Quality performance data should be stratified by social risk factors, which may include but are not limited to race, ethnicity, language, disability, sexual orientation, and gender identity. The Contractor shall describe how the data is used to monitor progress toward health equity goals and objectives. In addition, the Contractor shall include:

2.14.13.2.2.1.1. Data submissions that specifically support the executive summary, including additional data requested by EOHHS;

2.14.13.2.2.1.2. Baseline values or an explanation of why a baseline value is not available;

2.14.13.2.2.1.3. A description of which interventions support the progress toward plan goals and objectives and how they will support such progress;

2.14.13.2.2.1.4. As applicable, a description of what contributed to the achievement of the interventions;

2.14.13.2.2.1.5. A description of how plans are ensuring equitable access to healthcare; and

2.14.13.2.2.1.6. A description of how plans deliver high-quality care that continuously reduces inequities.

2.14.13.2.3. Stakeholder Collaboration: How the Contractor sought and incorporated input from stakeholders, including the SCO Advisory Committee, the Consumer Advisory Board, and Providers representing the composition of the Contractor's Provider Network such as community hospitals, other community-based providers, ASAPs, Enrollees, and Enrollees' families;

2.14.13.2.4. Health Equity Trainings: The Contractor's approaches to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, cultural competency, and advocacy, including through the provision of trainings for health equity, implicit bias, anti-racism, and related trainings. Trainings shall be periodically received by all staff and Network Providers (contracted or directly employed) that interact with Medicaid Enrollees (through operations, delivery of services, or other patient interfacing roles (e.g., security officer or receptionist); and

2.14.13.2.5. Policy and Procedures: The Contractor's approach to reviewing policy and procedures for impact on health inequities and how they will update such policy and procedures to mitigate such inequities. In addition, the Contractor shall describe how policy and procedures are designed to promote health equity where possible and in accordance with all federal and state law, including but not limited to 1) marketing strategy, 2) enrollment and disenrollment, 3) medical, behavioral health, and other health services policies, 4) enrollee and provider outreach, 5) grievances and appeals, 6) utilization management, and 7) Flexible Benefits.

2.14.13.3. The Contractor shall identify gaps in the achievement of targeted goals and objectives, observed barriers to achieving goals and objectives, and specific plans for the upcoming year to overcome such gaps.

2.14.13.4. At EOHHS's request, the Contractor shall meet with EOHHS to discuss its reporting on items in this Section.

2.14.13.5. The Contractor shall publicly post the executive summaries of its Health Equity Strategic Plan, update them annually, and make these documents available to EOHHS for posting on EOHHS's website.

2.14.14. Optional Community Needs Assessment

2.14.14.1. The Contractor may implement a Population and Community Needs Assessment to inform the Five-year Health Equity Strategic Plan. The content of the Community Needs Assessment may include:

2.14.14.1.1. A brief description of the population of Enrollees the Contractor serves and the communities in which they live,

2.14.14.1.2. A description of the characteristics of such population and communities, including at a minimum:

2.14.14.1.2.1. The approximate number of Enrollees in the population,

2.14.14.1.2.2. The population's demographic characteristics, including but not limited to age, race, ethnicity, languages spoken, disability status, sexual orientation, gender identity, and,

2.14.14.1.2.3. A description of any other salient characteristics of the population that inform the Contractor's strategy for improving the quality and cost of Enrollee care, such as any particular public or environmental health concerns.

2.14.14.1.3. A description of the health, functional, and other care needs of such population and communities, including but not limited to:

2.14.14.1.3.1. A list and description of prevalent conditions in the population, including chronic diseases;

2.14.14.1.3.2. A description of the population's behavioral health needs;

2.14.14.1.3.3. A description of the population's LTSS needs;

2.14.14.1.3.4. A description of the population's health-related social needs; and

2.14.14.1.3.5. A description of the community resources that currently exist in such communities.

2.14.15. NCQA Health Equity Accreditation

2.14.15.1. The Contractor may pursue accreditation by the National Committee on Quality Assurance (NCQA) for its Health Equity Accreditation program. If the Contractor is pursuing or is already NCQA Health Equity Accredited, the Contractor shall:

2.14.15.1.1. Annually, inform EOHHS if it is nationally accredited through NCQA or if it has sought and been denied such accreditation.

2.14.15.2. As directed by EOHHS, submit a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any to EOHHS; and

2.14.15.3. Authorize NCQA to provide EOHHS a copy of the Contractor's most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings, and the expiration date of accreditation.

2.15. Data Management, Information Systems Requirements, and Reporting Requirements

2.15.1. General Requirements

2.15.1.1. The Contractor shall:

2.15.1.1.1. Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS's requirements as outlined in this Contract, as described in this **Section 2.15** and as further directed by EOHHS;

2.15.1.1.2. Ensure a secure, HIPAA-compliant exchange of Member and Enrollee information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to and from EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS, as further directed by EOHHS;

2.15.1.1.3. 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 locate all relevant information quickly and easily. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website;

2.15.1.1.4. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and

2.15.1.1.5. Actively participate in any EOHHS data management workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS.

2.15.2. Encounter Data

2.15.2.1. The Contractor shall collect, manage, and report Encounter Data as described in this Section and as further specified by EOHHS, including specifications documented in **Appendix H**, which EOHHS may update at any time. The Contractor shall:

2.15.2.1.1. Collect and maintain one hundred percent (100%) Encounter Data for all SCO Covered Services provided to Enrollees, including services provided through any Material Subcontractor, including from any sub-capitated sources. Such data must be able to be linked to MassHealth eligibility data; specifically:

2.15.2.1.1.1. All Medicare services provided to Enrollees, including Medicare Parts A, B, and D services and Medicare Supplemental Benefits;

2.15.2.1.1.2. All MassHealth services described in **Appendix C**; and

2.15.2.1.1.3. Flexible Benefits.

2.15.2.1.2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;

2.15.2.1.3. Participate in data management reviews to identify and remediate Encounter Data gaps in advance of key business process deadlines upon request of EOHHS;

2.15.2.1.4. Upon request by EOHHS, or its designee, assist with validation assessments by providing Enrollees' medical records and a report from specified administrative databases of the Encounters related to those Enrollees;

2.15.2.1.5. Produce, maintain, and validate Encounter Data according to the specifications, format, and mode of transfer established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include data elements described in **Appendix H**, specified information about the delivering provider, and elements and level of detail determined necessary by EOHHS. Required data elements may be updated at the discretion of EOHHS. As directed by EOHHS, such Encounter Data shall also include:

2.15.2.1.5.1. The most current version of Encounters;

2.15.2.1.5.2. 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;

2.15.2.1.5.3. Information related to denied claims and 340B Drug Rebate indicators; and

2.15.2.1.5.4. All SCO Covered Services provided to Enrollees as described in **Section 2.7** above and **Appendix C**.

2.15.2.1.6. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix H**.

2.15.2.1.7. Submit Encounter Data that is at a minimum ninety-nine (99%) percent complete and ninety-five (95%) percent accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the Contractor shall have systems in place to monitor and audit claims. The Contractor shall also correct and resubmit denied encounters as necessary. The Contractor shall meet data quality requirements regarding completeness, accuracy, timeliness, and consistency to ensure Encounter Data is correct, provable, and trusted.

2.15.2.1.8. Correct and resubmit rejected Encounter Data as necessary. The Contractor shall submit any correction and manual override files 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 H**.

2.15.2.1.9. 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. At EOHHS's request, the Contractor shall submit denied claims as part of its Encounter Data submission, as further specified by EOHHS.

2.15.2.1.10. As further described in Appendix H, submit on a monthly basis a crosswalk between the Contractor's internal provider identification numbers and MassHealth PID/SLs in coordination with MassHealth.

2.15.2.1.11. Comply with any modifications EOHHS makes to 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.

2.15.2.1.12. At a time specified by EOHHS, 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 a different format. This may also require the Contractor to assess testing milestones, provide a stabilization plan, and monitor timeliness of post-production issue resolution.

2.15.2.1.13. Participate in, and be responsive to requests for information during, EOHHS's quarterly assessment of the Contractor's Encounter Data submissions. Such assessment shall include, but may not limited to, determining the Contractor's compliance with the following:

2.15.2.1.13.1. Meeting the specifications in **Appendix H;**

2.15.2.1.13.2. Being responsive to Encounter Data related inquiries by EOHHS, including but not limited to investigations of data observations and implementation of data fixes;

2.15.2.1.13.3. Avoiding critical failures or disruptions to EOHHS's data submission, processing, and downstream analytics; and

2.15.2.1.13.4. Meeting the completeness, accuracy, timeliness, quality, form, format, and other standards in this **Section 2.15.2** and as further specified by EOHHS.

2.15.2.2. If EOHHS, or the Contractor, determines at any time, including during any of the quarterly assessments described in **Section 2.15.2.1.13**, that the Contractor's Encounter Data is not compliant with the specifications described in **Section 2.15.2.1.13**, the Contractor shall:

2.15.2.2.1. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate,

2.15.2.2.2. Submit for EOHHS approval, within a time frame established by EOHHS which shall not exceed thirty (30) days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a data remediation action plan and timeline for resolution to bring the accuracy and completeness to an acceptable level.

2.15.2.2.2.1. Such action plan shall be reviewed and approved by EOHHS. The Contractor shall modify its proposed action plan as requested by EOHHS.

2.15.2.2.2.2. The Contractor may request an extension at least three business days prior to the due date of the data remediation action plan described in this **Section 2.15.2**, including with its request the reason for the needed extension and an action plan and timeline for when the Contractor is able to submit its proposed action plan.

2.15.2.2.2.3. Implement the EOHHS-approved data remediation plan within a time frame approved by EOHHS, which shall not exceed thirty (30) days from the date that the Contractor submits the data remediation plan to EOHHS for approval; and

2.15.2.2.2.4. Participate in a validation study to be performed by EOHHS following the end of a twelve (12)month period after the implementation of the data remediation action plan to assess whether the Contractor's Encounter Data is compliant with the standards described in **Appendix H**.

2.15.2.3. If the Contractor fails to satisfy the data remediation plan requirements as set forth in **Section 2.15.2.2**, EOHHS may apply a capitation payment deduction as specified in **Section 5.4.2**.

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

2.15.3. Medicaid Drug Rebate

2.15.3.1. The Contractor shall collect, manage, and report Drug Rebate Data as described in this Section and as further specified by EOHHS. The Contractor shall:

2.15.3.2. Collect and retain 100% of the Drug Rebate Data in accordance with **Appendix Q**. In addition, the Contractor shall:

2.15.3.2.1. Ensure Drug Rebate Data is consistent with MassHealth eligibility data;

2.15.3.2.2. Create and maintain the file record layouts/schemas in accordance with EOHHS requirements for the purposes of capturing and submitting all drug claims to EOHHS and its designee. The Contractor shall satisfy any EOHHS-required timely updates to the file record layouts/schema in response to changing requirements;

2.15.3.2.3. As directed by EOHHS, include as part of its Drug Rebate Data information related to denied claims and 340B Drug Rebate indicators;

2.15.3.2.4. In the event EOHHS or its designee is unable to accept certain Drug Rebate Data records due to validation errors, retrieve and promptly correct those claim records and resubmit them in accordance with current EOHHS schema and schedules;

2.15.3.2.5. Participate in workgroups, discussions, and meetings with EOHHS and its designees to support MassHealth rebate invoicing to drug manufacturers;

2.15.3.2.6. Validate that all National Drug Codes (NDCs) submitted on physician-administered drugs for rebate match the Healthcare Common Procedure System (HCPCS) being billed for, and include accurate NDC information (unit of measure and quantity);

2.15.3.2.7. Instruct Providers to use the following indicators to identify 340B claims:

2.15.3.2.7.1. For Physician-administered Drugs add the identifier of "UD" to the HCPCS;

2.15.3.2.7.2. For Pharmacy-dispensed drugs attach Submission Clarification Code 20; and

2.15.3.2.8. Perform all system and program activities determined necessary to:

2.15.3.2.8.1. Properly identify drugs purchased through the Federal 340B Drug Pricing Program; and

2.15.3.2.8.2. Collect all of the following information on claims for physician-administered drugs and deny any claim for such drugs that does not include all such information:

2.15.3.2.8.2.1. All information set forth in 42 CFR 447.511 that EOHHS specifies the Contractor needs to provide, including but not limited to National Drug Code (NDC):

2.15.3.2.8.2.2. Metric Quantity; and

2.15.3.2.8.2.3. Unit of Measure;

2.15.3.2.9. 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 Drug Rebate Data;

2.15.3.2.10. Produce Drug Rebate Data according to the specifications, format, and mode of transfer reasonably developed by EOHHS or its designee;

2.15.3.2.11. Provide Drug Rebate Data to EOHHS monthly or within time frames specified by EOHHS, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations, and guidance;

2.15.3.2.12. Submit Drug Rebate Data that is 100% on time and 99% complete. To meet the completeness standard, all critical fields in the data must contain valid values. The Contractor shall correct and resubmit errored claims as necessary;

2.15.3.2.13. Report as voided or reversed any claims in the Drug Rebate Data submission that the Contractor includes in a file and then later determines should not have been included;

2.15.3.2.14. Ensure that the Drug Rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate file upload schedule whenever there is a change in the Drug Rebate operations or technical support staff;

2.15.3.2.15. If EOHHS or the Contractor determines at any time that the Contractor's Drug Rebate Data will not be or is not 100% on time and 99% complete:

2.15.3.2.15.1. Notify EOHHS, five days prior to the Drug Rebate Data scheduled submission date, that the Drug Rebate Data will not be delivered on time or is not complete and provide an action plan and timeline for resolution;

2.15.3.2.15.2. Submit a corrective action plan to EOHHS, for approval, within a timeframe not to exceed thirty (30) days, from the day the Contractor identifies or is notified that it is not in compliance with the Drug Rebate Data requirements, to implement improvements or enhancements to bring the timeliness and completeness to an acceptable level;

2.15.3.2.15.3. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed thirty (30) days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

2.15.3.2.15.4. 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 Drug Rebate Data is 100% on time and 99% complete. The Contractor may be financially liable for such validation study.

2.15.3.2.16. Operate and maintain a state-of-the-art National Council for Prescription Drug Programs (NCPDP)-compliant, online pharmacy claims processing system. Such system shall allow for having a separate BIN, PCN, and group number combination for MassHealth claims to differentiate them from other claims. The Contractor shall notify EOHHS of BIN, PCN, and group number combination changes as set forth in **Appendix A**.

2.15.3.2.17. With respect to drugs and drug classes specified by EOHHS, provide coverage in a manner that maximizes EOHHS's ability to collect drug rebates, including but not limited to excluding such drugs and drug classes from reimbursement through the Contractor's 340B program, as further specified by EOHHS.

2.15.4. Outpatient Drugs

2.15.4.1. 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.

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

2.15.5. Medical Records

2.15.5.1. Documentation Standards

2.15.5.1.1. The Contractor shall use and require commonly accepted standards for medical record documentation, as follows:

2.15.5.1.1.1. Each page in the record contains the patient's name or ID number;

2.15.5.1.1.2. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials;

2.15.5.1.1.3. All entries are dated;

2.15.5.1.1.4. The record is legible to someone other than the writer;

2.15.5.1.1.5. Significant illnesses and medical conditions are indicated on the problem list;

2.15.5.1.1.6. Encounter forms or notes have a notation regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months, or as needed;

2.15.5.1.1.7. Unresolved problems from previous office visits are addressed in subsequent visits;

2.15.5.1.1.8. There is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals;

2.15.5.1.1.9. If a consultation is requested, there is a note from the specialist in the record;

2.15.5.1.1.10. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure; and

2.15.5.1.1.11. There is evidence that preventive screening and services are offered in accordance with the Provider's own practice guidelines, including the administration of behavioral health screenings.

2.15.5.2. Provide Records to EOHHS

2.15.5.2.1. The Contractor shall:

2.15.5.2.1.1. Provide a copy of the Centralized Enrollee Record and other medical records pertaining to Enrollees, at EOHHS's 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 under this contract. Medical record audits conducted by the Contractor at the request of EOHHS may be subject to validation performed directly by EOHHS or its designee.

2.15.5.2.1.2. Provide any such medical or audit record(s) within 10 days of EOHHS's request, provided however, that EOHHS may grant the Contractor up to thirty (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.

2.15.5.2.1.3. In the event of termination or expiration of the Contract, or in the event of Enrollee disenrollment, transfer all medical records and other relevant information in the Contractor's possession, in a format to be specified by EOHHS, to EOHHS, another Contractor, or other party as determined by EOHHS.

2.15.5.3. Data through Health Information Systems (HIS)

2.15.5.3.1. The Contractor shall ensure its HIS collects, analyzes, integrates, and reports data, including, but not limited to information regarding:

2.15.5.3.1.1. Utilization (including Medicare and Medicaid Covered Services, Medicare Supplemental Benefits, and Flexible Benefits) and claims;

2.15.5.3.1.2. Inquiries, Grievances, Appeals, including Internal and External Appeals, External Appeals includes Appeals escalated to both Medicare and Medicaid Appeal processes;

2.15.5.3.1.3. Voluntary Disenrollments as described in **Section 2.4.12.3**;

2.15.5.3.1.4. Provider information in order to comply with **Section 2.11.1.1.5**;

2.15.5.3.1.5. Services furnished to Enrollees through an Encounter Data system, as specified in **Section 2.15.2**;

2.15.5.3.1.6. Enrollee characteristics, including but not limited to, accommodation requests, disability type, homelessness, race, ethnicity, primary language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheelchair use, sexual orientation and gender identity, and characteristics gathered through such Plan contact with Enrollees, e.g., intake and other screenings during Onboarding, Assessment processes, Care Management, or other reliable means; and

2.15.5.3.1.7. Care Coordination activities, status, responsibilities, and other information, including the mode of Care Coordination

provided, such as documenting in-person engagement and in-home visits, video vs. audio only virtual engagement.

2.15.5.4. Data Integrity Standards

2.15.5.4.1. The Contractor shall:

2.15.5.4.1.1. Ensure that data received from Providers is 99% complete and 95% accurate by:

2.15.5.4.1.2. Verifying the accuracy and timeliness of reported data, including data from Network Providers the Contractor is compensating on the basis of capitation payments;

2.15.5.4.1.3. Screening the data for completeness, logic and consistency; and

2.15.5.4.1.4. 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, pursuant to 42 CFR 438.242(b)(3)(iii).

2.15.5.4.1.5. Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(4).

2.15.5.5. Design Requirements

2.15.5.5.1. The Contractor shall:

2.15.5.5.1.1. 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.

2.15.5.5.1.2. Ensure the Contractor's Systems interface with EOHHS's Legacy MMIS system, EOHHS's MMIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture as further specified by EOHHS;

2.15.5.5.1.3. Have adequate resources to support the MMIS interfaces referenced in **Appendix J**. The Contractor shall demonstrate the capability to successfully send and receive interface files, as specified in **Appendix J** of this Contract.

2.15.5.5.1.4. Conform to HIPAA compliant standards for data management and information exchange.

2.15.5.5.1.5. Demonstrate controls to maintain information integrity.

2.15.5.5.1.6. Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS, consistent with **Section 2.15.5.4**.; and

2.15.5.5.1.7. As set forth in 42 CFR 438.242(b)(1), comply with Section 6504(a) of the Affordable Care Act.

2.15.5.6. Centralized Enrollee Record

2.15.5.6.1. To coordinate care, the Contractor shall maintain a single, centralized, comprehensive electronic record that documents the Enrollee's medical, prescription, functional, and social status. The Contractor shall ensure that the PCP and all Members of the ICT, including the GSSC Coordinator, as well as any other appropriate providers, including Contractors, and Related Entities, make appropriate and timely entries describing the care provided, clinical assessments, diagnoses determined, medications prescribed, treatment plans, treatment services provided, treatment goals and outcomes, and pharmacy records.

2.15.5.6.2. The Centralized Enrollee Record shall contain the following:

2.15.5.6.2.1. Enrollee identifying information and demographic information (including race, ethnicity, disability type, primary language, and homelessness), and family and caregiver contact information;

2.15.5.6.2.2. Personal biographical data include the address, home telephone, mobile telephone, and work telephone numbers, name of employer, marital status, and primary language spoken;

2.15.5.6.2.3. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted, and for prescribed medications, including dosages and any known drug contraindications;

2.15.5.6.2.4. Documentation of physical access and programmatic access needs of the Enrollee, as well as needs for accessible medical equipment;

2.15.5.6.2.5. Documentation of the Enrollee’s communication preferences (e.g., text, email, phone, etc.) and communication access needs, including live interpreting services, access to telephone devices and advanced

technologies that are hearing aid compatible, and video relay service or point-to-point video, for Enrollees who are Deaf or hard of hearing;

2.15.5.6.2.6. Documentation of Comprehensive Assessments, including diagnoses, prognoses, plans of care, and treatment and progress notes, signed and dated by the appropriate provider; and

2.15.5.6.2.7. Ensure that documentation of behavioral health treatment in the Centralized Enrollee Record includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed (psychotherapeutic session notes shall not be recorded in the Centralized Enrollee Record).

2.15.5.6.2.8. Laboratory and radiology reports;

2.15.5.6.2.9. Updates on the Enrollee’s involvement and participation with community agencies that are not part of the Provider Network, including any services provided;

2.15.5.6.2.10. Physician orders;

2.15.5.6.2.11. Enrollee's individual Advance Directives and health care proxy, recorded and maintained in a prominent place;

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

2.15.5.6.2.13. Emergency psychiatric crisis plans;

2.15.5.6.2.14. Allergies and special dietary needs; and

2.15.5.6.2.15. Information that is consistent with the utilization control requirement of 42 C.F.R. 456 et. seq.

2.15.5.6.3. Coordination of Centralized Enrollee Record Information: systems shall be implemented to ensure that the Centralized Enrollee Record is:

2.15.5.6.3.1. Maintained in a manner that is current, detailed, and organized and that permits effective patient care, utilization review and quality review by each applicable provider of care;

2.15.5.6.3.2. Available and accessible twenty-four (24) hours per day, seven (7) days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care providers for Emergency Medical Conditions and Urgent Care; and

2.15.5.6.3.3. Available and accessible to specialty, LTSS, mental health and SUD providers, and to LTS Coordinators.

2.15.6. Health Information Technology and Health Information Systems

2.15.6.1. General

2.15.6.1.1. The Contractor shall, as further specified by EOHHS, establish and implement policies and procedures to:

2.15.6.1.1.1. Enhance interoperability of its health information technology through health information exchange technologies;

2.15.6.1.1.2. Increase utilization of health information exchange services operated or promoted by the Mass HIway, including but not limited to direct messaging, Statewide event notification service (ENS) Framework, and Query and Retrieve functionality;

2.15.6.1.1.3. Upon notification by EOHHS that additional Mass HIway services are developed, operated, or promoted, establish and implement policies and procedures to increase connectivity to such services and work with its Network PCPs to increase their connectivity;

2.15.6.1.1.4. Ensure effective linkages of clinical and care management information systems to facilitate timely information sharing, including through the Enrollee's electronic medical record, among all Providers, including clinical subcontractors and GSSC Coordinators, in accordance with national technical standards where applicable; and

2.15.6.1.1.5. Leverage information sharing and communication that facilitates and improves coordination of care, including among the ICT Members and the Enrollee's GSSC or other designated care coordinator, including for care provided outside of the primary care site, for referrals, and for discharge planning and other care transitions.

2.15.6.1.2. The Contractor shall provide EOHHS with such policies and procedures described above upon EOHHS request.

2.15.6.2. Quality Data Collection

2.15.6.2.1. The Contractor shall plan to develop, establish, or enhance existing Electronic Clinical Data Systems (ECDS), with the capability to collect data to calculate Electronic Clinical Quality Measures (eCQMs) or Digital Quality Measures (dQMs) as directed by EOHHS. The Contractor shall submit data or results for eCQM, dQM or other electronic measures to EOHHS as directed by EOHHS.

2.15.6.2.2. For the purposes of quality management and Rating Category determination, the Contractor shall accept, process, and report to EOHHS uniform person level Enrollee data, based upon a Comprehensive Assessment process that includes ICD 10 diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0 or 3.0), and any other data elements deemed necessary by EOHHS.

2.15.6.3. Communication Technology Resources for Network Providers

2.15.6.3.1. The Contractor shall ensure that its Network PCPs are able to access or receive event notifications from an EOHHS-Certified ENS Vendor participating in the Statewide ENS Framework. The Contractor shall also establish and implement policies and procedures for its Network PCPs to integrate such event notifications into appropriate Care Management or population health management workflows.

2.15.6.3.2. The Contractor shall ensure that its Network PCPs enable and utilize Query and Retrieve functionality that is natively available in the Network PCPs' EHRs, as further specified by EOHHS.

2.15.6.3.3. The Contractor shall have at least 75% of its Providers who are EHR Eligible Clinicians adopt and integrate interoperable Electronic Health Records (EHR) certified by the Office of the National Coordinator (ONC) using ONC's 2015 certification edition, along with subsequent edits to the 2015 certification edition pursuant to the 21st Century Cures Act.

2.15.6.4. Health Information Systems (HIS)

2.15.6.4.1. The Contractor shall maintain a health information system (HIS) or Information Systems (together, the Contractor's Systems);

2.15.6.4.2. Such systems shall enable the Contractor to meet all of EOHHS's 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 as they may be updated from time to time:

2.15.6.4.2.1. The EOHHS Unified Process Methodology User Guide;

2.15.6.4.2.2. The User Experience and Style Guide Version 2.0;

2.15.6.4.2.3. Information Technology Architecture Version 2.0; and

2.15.6.4.2.4. Enterprise Web Accessibility Standards 2.0.

2.15.6.4.3. Upon EOHHS request, the Contractor shall provide to EOHHS data elements from the automated data system necessary for program integrity, program oversight, and administration to cooperate with EOHHS data processing and retrieval systems requirements.

2.15.7. Claims Processing Requirements

2.15.7.1. The Contractor shall operate and maintain an industry standard HIPAA-compliant, online Claims processing system that includes but is not limited to the following characteristics:

2.15.7.1.1. Supports HIPAA standard Inbound and Outbound Transactions, as defined by EOHHS:

2.15.7.1.1.1. Health Care Claim Status Request and Response (276/277)

2.15.7.1.1.2. Health Care Services Review – Request and Response (278)

2.15.7.1.1.3. Health Care Claim Payment/Advice (835)

2.15.7.1.1.4. Health Care Claim/Professional (837P)

2.15.7.1.1.5. Health Care Claim/Institutional (837I)

2.15.7.1.1.6. Health Care Eligibility Benefit Inquiry and Response (270/271)

2.15.7.1.1.7. Functional Acknowledgement for Health Care Insurance (997)

2.15.7.1.1.8. Implementation Acknowledgement for Health Care Insurance (999)

2.15.7.1.2. Complies with all future updates to the HIPAA transactions and standards within the required timeframes;

2.15.7.1.3. Has flexibility to receive Provider claims submitted in various HIPAA compliant formats. The Contractor shall collaborate with

Providers to allow Providers to submit Claims utilizing various industry standard procedures; and

2.15.7.1.4. Adjudicates Claims submitted in accordance with the timeframes specified in **Section 2.8.5**.

2.15.7.2. Additional Requirements

2.15.7.2.1. In addition, the Contractor shall:

2.15.7.2.1.1. Implement timely filing initiatives to ensure that Claims are submitted within the allotted time restrictions set by the Contractor;

2.15.7.2.1.2. Implement waiver parameters for Providers that do not meet allotted time restrictions including but not limited to a waiver at the request of EOHHS; and

2.15.7.2.1.3. Implement and maintain policies and procedures related to the financial, eligibility, and clinical editing of Claims. These policies and procedures shall include an edit and audit system that allows for editing for reasons such as, ineligibility of Enrollees, providers and services, duplicate services, and rules or limitations of services. As further specified by EOHHS, the Contractor shall report these edits to EOHHS.

2.15.7.3. Claims Review

2.15.7.3.1. The Contractor shall:

2.15.7.3.1.1. Maintain written, EOHHS-approved Claims resolution protocols. The Contractor shall submit any proposed changes to such protocols to EOHHS for prior review and approval and implement such changes upon the date specified by EOHHS;

2.15.7.3.1.2. Review Claims resolutions protocols no less frequently than annually and, as appropriate, recommend modifications to the protocols to EOHHS to increase the efficiency or quality for the Claims resolution process;

2.15.7.3.1.3. Review suspended Claims for reasons why Claims were suspended, including reasons specified by EOHHS;

2.15.7.3.1.4. Review all Claims that suspend for being untimely in accordance with EOHHS-approved protocols. The Contractor shall waive the timeliness deadline for those

Claims meeting the EOHHS-approved criteria as described in **Section 2.15.1** and as further described by EOHHS; and

2.15.7.3.1.5. Implement appropriate quality control processes to ensure that Claim review requirements are met within EOHHS-defined parameters including but not limited to maintaining an electronic record or log of the quality review process.

2.15.7.4. Recoveries and Erroneous Payments

2.15.7.4.1. The Contractor shall notify EOHHS of recoveries and erroneous payments as described in **Section 2.3.6**.

2.15.7.4.2. The Contractor shall at a minimum have systems in place to monitor and audit claims.

2.15.8. Reporting Requirements

2.15.8.1. General

2.15.8.1.1. The Contractor shall provide and require its Material Subcontractors to provide, in accordance with the timelines, definitions, formats, and instructions contained herein or as further specified by EOHHS:

2.15.8.1.2. All information EOHHS requires under this Contract, including the requirements of this Section, in **Appendix A**, and other information related to the Contractor's performance of its responsibilities hereunder or under subcontracts, including non-medical information for the purposes of research and evaluation;

2.15.8.1.2.1. Any information EOHHS requires to comply with all applicable federal or State laws and regulations;

2.15.8.1.2.2. Any information EOHHS requires for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievnaces and Appeals and enrollment/disenrollment rates;

2.15.8.1.2.3. Provide any information in its or its Material Subcontractors' possession sufficient to permit EOHHS to comply with 42 C.F.R. § 438;

2.15.8.1.2.4. Any data from their clinical systems, authorization systems, claims systems, medical record reviews, Network Management visits, and Enrollee and family input;

2.15.8.1.2.5. Time sensitive data to EOHHS in accordance with EOHHS timelines; and

2.15.8.1.2.6. High quality, accurate data in the format and in the manner of delivery specified by EOHHS;

2.15.8.1.3. Where practicable, EOHHS shall consult with the Contractor to establish time frames and formats and detailed specifications reasonably acceptable to both parties,

2.15.8.1.4. The Contractor shall participate in work groups led by EOHHS to develop and comply with reporting specifications and to adopt the reporting models formulated by these work groups and approved by EOHHS, pursuant to the timeline established by EOHHS; and

2.15.8.1.5. Upon request, provide EOHHS with the original data sets, stratified by EOHHS standards, used by the Contractor in the development of any required reporting or ad hoc reporting in accordance with the time frames and formats established by EOHHS.

2.15.8.2. Contract-related Reports

2.15.8.2.1. The Contractor shall meet all Contract-related report and data submission requirements, which include, but are not limited to, reports related to Contract performance, management, and strategy as set forth in **Appendix A**.

2.15.8.2.1.1. The Contractor shall submit **Appendix A** reports in accordance with the timeframes and other requirements specified in **Appendix A**, and consistent with any form and format requirements specified by EOHHS.

2.15.8.2.1.2. For any report that indicates the Contractor is not meeting a target set by EOHHS, the Contractor shall provide immediate notice explaining the corrective actions it is taking to improve performance. Such notice shall include root cause analysis of the problem the data indicates, the steps the Contractor has taken to improve performance, and the results of the steps taken to date. The Contractor may also include an executive summary to highlight key areas of high performance and improvement.

2.15.8.2.1.3. Failure to meet the reporting requirements in **Appendix A** shall be considered a breach of Contract.

2.15.8.2.1.4. Furthermore, the Contractor shall submit to EOHHS all applicable MassHealth reporting requirements in compliance with 42 C.F.R. § 438.602- 606, as detailed in **Appendix A**.

2.15.8.3. Personal Care Management (PCM) Agency Reporting

2.15.8.3.1. 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:

2.15.8.3.1.1. The number of overtime approval requests received; and

2.15.8.3.1.2. The number of overtime approval requests submitted to MassHealth.

2.15.8.4. Internal Management Reports

2.15.8.4.1. Upon request, any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance.

2.15.8.5. Additional Reports

2.15.8.5.1. In addition to the reports specifically required in **Appendix A**, the Contractor shall participate with EOHHS in the development of additional reports based on specific topics identified jointly by EOHHS and the Contractor as a result of ongoing analysis and review of data, and/or administrative and clinical processes. The Contractor shall participate in meetings led by EOHHS to develop analytical approaches and specifications for such reports. The Contractor shall produce data and written analyses of each topic in a time frame established by EOHHS but, at minimum, by the end of each Contract Year.

2.15.8.5.2. The Contractor shall provide EOHHS, in a form and format approved by EOHHS and in accordance with the timeframes established by EOHHS, all reports, data or other information EOHHS determines are necessary for compliance with the provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance. Further, the Contractor shall correct any errors in such reports in accordance with EOHHS guidelines.

2.15.8.5.3. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with program report requirements set forth in 42 CFR 438.66(e).

2.15.8.5.4. The Contractor shall report to EOHHS in a form and frequency specified by EOHHS, payment discrepancies and enrollment discrepancies, and

2.15.8.5.5. The Contractor shall provide and require its Material Subcontractors to provide any information required for the implementation and operation of Electronic Visit Verification (EVV) to ensure that the Contractor's EVV systems comply with the requirements outlined in Section 12006 of the 21st Century Cures Act (codified as 42 USC 1396b(l)) and as directed by EOHHS.

2.15.8.6. Other Ad Hoc Reports

2.15.8.6.1.1. The Contractor shall provide EOHHS with additional ad hoc or periodic reports related to this Contract at EOHHS's request in the time frame and format specified by EOHHS.

2.15.8.7. Quality Survey Data

2.15.8.7.1. The Contractor shall submit to EOHHS all quality, survey, Member experience, process, and other data required by CMS and submitted to CMS or its designee in accordance with the Contractor's Medicare D-SNP contract for its SCO plan.

2.15.8.7.2. The Contractor shall report to EOHHS annually all collected HEDIS, HOS, and CAHPS data, as well as measures related to LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements, plus additional Medicaid measures required by EOHHS.

2.15.8.7.3. In accordance with **Section 2.14.2.2.3**, and as further specified by EOHHS, the Contractor shall submit HEDIS data annually, six (6) months after the end of the HEDIS reporting period in accordance with the format, method and time frames specified by EOHHS.

2.15.8.8. Grievances and Appeals

2.15.8.8.1. In a form, format, and frequency specified by EOHHS, and as described in **Appendix A**, the Contractor shall report:

2.15.8.8.2. 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 2.13**). The Contractor shall cooperate with EOHHS to implement improvements based on the findings of these reports.

2.15.8.8.3. The number, types, status, resolutions, and associated timeframes of Appeals filed (see **Section 2.13**) as well as information on Continuing Services requested or provided, for External Appeals, the Contractor shall report Appeals that go through the CMS Medicare Appeals process (e.g. beginning with the CMS Independent Review

Entity), the Medicaid Appeals process (e.g. beginning with the MassHealth Board of Hearings), or both.

2.15.8.9. Functional Data

2.15.8.9.1. In a form and format specified by EOHHS, the Contractor shall 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 Assessment for Rating Category Assignment described in **Section 4.1** 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:

2.15.8.9.1.1. Mobility;

2.15.8.9.1.2. Transfer;

2.15.8.9.1.3. Dressing;

2.15.8.9.1.4. Eating;

2.15.8.9.1.5. Toilet use;

2.15.8.9.1.6. Personal hygiene; and

2.15.8.9.1.7. Bathing.

2.15.8.10. Mortality Data

2.15.8.10.1. In a form and format specified by EOHHS, the Contractor shall report mortality data annually, by age and gender, in the following categories:

2.15.8.10.1.1. The number of Enrollees who died during the past year;

2.15.8.10.1.2. Percentage who died in hospitals;

2.15.8.10.1.3. Percentage who died in nursing facilities;

2.15.8.10.1.4. Percentage who died in community-based settings; and

2.15.8.10.1.5. Cause of death.

2.15.8.11. Medications

2.15.8.11.1. As directed by EOHHS, the Contractor shall report Enrollee-specific prescription data through MDS 3.0 for nursing residents and the MDS-HC (or its successor) for home care.

2.15.8.12. Frail Elder Waiver Reporting

2.15.8.12.1. The Contractor shall comply with the quality improvement performance measures as described in the Frail Elder Waiver. The Contractor shall submit all materials requested by EOHHS to document the Contractor's compliance with these quality improvement performance measures, in accordance with the form and schedule prescribed by EOHHS.

2.15.9. Related Systems

2.15.9.1. Systems Access Management and Information Accessibility Requirements

2.15.9.1.1. 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.

2.15.9.1.2. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

2.15.9.2. System Availability and Performance Requirements

2.15.9.2.1. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.15.9.2.2. The Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to EOHHS upon request. In the event of System failure or unavailability, the Contractor shall notify EOHHS upon discovery and implement the COOP immediately.

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

2.15.9.3. Virtual Gateway

2.15.9.3.1. If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, or its successor information system, the Contractor shall:

2.15.9.3.1.1. Submit all specified information including, but not limited to, MDS-HC (or successor) assessment data, invoices,

Contract or other information to EOHHS through these web-based applications;

2.15.9.3.1.2. Comply with all applicable EOHHS policies and procedures related to such services;

2.15.9.3.1.3. Use all business services through the Virtual Gateway as required by EOHHS;

2.15.9.3.1.4. Take necessary steps to ensure that it, and its Material Subcontractors or affiliates, have access to and utilize all required web-based services; and

2.15.9.3.1.5. Execute and submit all required agreements, including subcontracts, Memoranda of Agreements, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.

2.15.9.4. Notification of Hospital Utilization

2.15.9.4.1. The Contractor shall indicate, as set forth in **Appendix A**, at a frequency specified by EOHHS, that it has notified each Massachusetts acute hospital of the number of inpatient days of service provided by each hospital to Enrollees who receive inpatient hospital services under this Contract pursuant to M.G.L. c. 118E, § 13F.

2.15.9.5. Certification Requirements

2.15.9.5.1. In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive Officer or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit to EOHHS certification checklists in the form and format provided in **Appendix A**, certifying that the information, data, and documentation being submitted by the Contractor is true, accurate, and complete to the best of their knowledge, information and belief, after reasonable inquiry, under the penalty of perjury:

2.15.9.5.1.1. Data on which payments to the Contractor are based;

2.15.9.5.1.2. All enrollment information, Encounter Data, and measurement data;

2.15.9.5.1.3. Data related to medical loss ratio requirements in aggregate for the Contractor's Enrollee population;

2.15.9.5.1.4. Data or information related to protection against the risk of insolvency;

2.15.9.5.1.5. Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor's Provider Network;

2.15.9.5.1.6. Information on ownership and control, such as that pursuant to **Section 5.1.11.2.1**;

2.15.9.5.1.7. Reports related to overpayments; and

2.15.9.5.1.8. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

2.15.9.6. Update Enrollee Address and Other Information

2.15.9.6.1. With Enrollee consent, the Contractor shall assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including, ethnicity, and race, by entering the updated information in a form and format specified by EOHHS, as follows:

2.15.9.6.1.1. If the Contractor learns from an Enrollee or an Authorized Representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or Authorized Representative, the Contractor shall provide such information to EOHHS after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

2.15.9.6.1.2. Prior to entering such demographic information, the Contractor shall advise the Enrollee as follows: "Thank you for this change of address [phone] information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required, but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."

2.15.9.6.1.3. If the Contractor receives updated demographic information from a third party, such as a Provider, a vendor hired to obtain demographic information, or through the post office, the Contractor shall confirm the new demographic information with the Enrollee, and obtain the Enrollee's permission, prior to submitting the information to EOHHS.

2.15.9.6.1.4. As applicable, the Contractor shall ensure that all appropriate staff entering this information into any EOHHS systems have submitted the documentation necessary to complete this function on any EOHHS systems and completed any necessary training requirements.

2.15.10. Online Portals

2.15.10.1. The Contractor shall develop, implement, and maintain Enrollee-facing and Provider-facing secure online portal functions for Enrollees and Providers.

2.15.10.2. EOHHS, in its sole discretion, may permit the Contractor to phase in required functionality over time. Provided the Contractor demonstrates good faith efforts and sufficient progress during Readiness Review, EOHHS may approve implementation for a date within the first Contract Year (2026), and after the Contract Operational Start Date.

2.15.10.3. Online portal functions shall include the following:

2.15.10.3.1. Electronic communication between the Care Coordinator and the Enrollee;

2.15.10.3.2. Ability to access (i.e. read) information from the Centralized Enrollee Record as described in **Section 2.15.5.6**, which may include:

2.15.10.3.2.1. Comprehensive Assessments as described in **Section 2.5.1**; and

2.15.10.3.2.2. Enrollee Care Plan as described in **Section 2.5.3**;

2.15.10.3.3. Status and tracking information for Service Requests as described in **Section 2.5.3.3** and for Authorizations as described in **Section 2.10.9**;

2.15.10.3.4. Electronic access to Enrollee Notices and Letters;

2.15.10.3.5. Information about upcoming Assessments, Care Team discussions, and Care Coordinator meetings;

2.15.10.3.6. Status and tracking information for Appeals and Grievances as described in **Section 2.13**; for Appeals, such information shall minimally include Appeal Level, disposition, and applicable time standards and deadlines; and

2.15.10.3.7. Ability to electronically submit an Appeal or Grievance as described in **Section 2.13**, including to attach, submit, or otherwise

update and access all related and supporting information on the Appeal or Grievance;

2.15.10.4. The Contractor shall ensure that Enrollee-facing and Provider-facing online portals are operational and available twenty-four hours a day, seven days a week, with minimal downtime for maintenance or updates, and shall adhere to all applicable state and federal requirements for privacy and security, accessibility, and communication access, including the requirements of **Section 2.12.3**; and

2.15.10.5. The Contractor shall make available support and assistance features for the online portals, including but not limited to technical assistance, user guides, and the ability to access live support from Enrollee Services (**Section 2.11**).

2.16. Financial Stability Requirements

2.16.1. General

2.16.1.1. The Contractor shall remain fiscally sound as demonstrated by meeting the criteria in this **Section 2.16**.

2.16.2. DOI Licensure

2.16.2.1. The Contractor shall be licensed as a Health Maintenance Organization by the Massachusetts Division of Insurance (DOI), pursuant to 211 CMR 43.

2.16.3. Cash Flow

2.16.3.1. The Contractor shall maintain sufficient cash flow and liquidity to meet obligations as they become due. The Contractor shall submit to EOHHS upon request a cash flow statement, and other financial documents, to demonstrate compliance with this requirement for a period specified by EOHHS.

2.16.4. Net Worth

2.16.4.1. The Contractor shall comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25(a) and 211 CMR 43:06(1).

2.16.5. Cash Reserves

2.16.5.1. Throughout the term of this Contract, the Contractor shall maintain a minimum cash reserve of $1,000,000 to be held in a restricted reserve entitled “Reserve for MassHealth Managed Care Obligations.” Funds from this restricted cash reserve may be dispersed only with prior written approval from EOHHS during the term of this Contract.

2.16.6. Working Capital Requirements

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

2.16.6.1.1. If, at any time, the Contractor's working capital decreases to less than 75% of the amount reported on the prior year's audited financial statements, the Contractor shall notify EOHHS within two business days and submit, for approval by EOHHS, a written plan to reestablish a positive working capital balance at least equal to the amount reported on the prior year's audited financial statements.

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

2.16.6.1.2.1. Does not maintain a positive working-capital balance;

2.16.6.1.2.2. Violates a corrective plan approved by EOHHS;

2.16.6.1.2.3. Does not propose a plan to reestablish a positive working capital balance within a reasonable period of time as determined by EOHHS; or

2.16.6.1.2.4. EOHHS determines that negative working capital cannot be corrected within a reasonable amount of time as determined by EOHHS.

2.16.7. Financial Stability Plan

2.16.7.1. Throughout the term of this Contract, the Contractor shall remain financially stable and maintain adequate protection against insolvency, as determined by EOHHS. To meet this general requirement, the Contractor, at a minimum, shall comply with, and demonstrate such compliance to the satisfaction of EOHHS, the solvency standards imposed on HMOs by the Massachusetts Division of Insurance (DOI). A DOI-licensed Contractor shall submit copies of its DOI financial reports to EOHHS on a quarterly basis. The Contractor shall also submit reports set forth in **Appendix A**.

2.16.7.2. The Contractor shall:

2.16.7.2.1. Provide to Enrollees all Covered Services required by this Contract for a period of at least forty-five (45) calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

2.16.7.2.2. 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

2.16.7.2.3. 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.

2.16.7.3. The Contractor shall immediately notify EOHHS when:

2.16.7.3.1. The Contractor has determined that the liquidity ratio, as determined by EOHHS, and reported in the quarterly financial reports in accordance with **Appendix A**, falls below 1.5.

2.16.7.3.2. The Contractor has reason to consider insolvency or otherwise has reason to believe it or any Material 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

2.16.7.4. The Contractor shall maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance; and annually demonstrate required liability protection to EOHHS.

2.16.7.5. Insolvency Reserve

2.16.7.5.1. The Insolvency Reserve shall be defined as the funding resources available to meet costs of providing services to Enrollees for a period of forty-five (45) days in the event that the Contractor is determined insolvent. Funding the Insolvency Reserve shall be the sole responsibility of the Contractor, regardless of any risk sharing arrangements with EOHHS.

2.16.7.5.2. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within forty-five (45) days of the start of the Contract Year.

2.16.7.5.3. The Insolvency Reserve calculation shall be an amount equal to forty-five (45) days of the Contractor's estimated medical expenses, not to exceed eighty-eight (88%) percent of the calculated value of forty-five (45) days of capitation payment revenue.

2.16.7.5.4. Within thirty (30) calendar days of receipt of the Insolvency Reserve calculation, the Contractor shall submit to EOHHS written

documentation of its ability to satisfy EOHHS's Insolvency Reserve Requirement. The documentation shall be signed and certified by the Contractor's chief financial officer.

2.16.7.5.5. Subject to EOHHS's approval, the Contractor may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; performance guarantee as specified in **Section 2.16.7.6**; insolvency insurance or reinsurance, performance bonds; irrevocable letter of credit; and other letters of credit or admitted assets as specified in **Appendix R**.

2.16.7.5.6. The Contractor must immediately notify EOHHS if the Contractor's net worth, as determined by EOHHS, falls below 133% of EOHHS's Insolvency Reserve Requirement.

2.16.7.6. Performance Guarantees and Additional Security

2.16.7.6.1. Throughout the term of this Contract, EOHHS, in its sole discretion, and as described in this **Section 2.16.7.6**, may require the Contractor to provide EOHHS with performance guarantees that are subject to prior review and approval from EOHHS.

2.16.7.6.2. Events that may require the Contractor to provide EOHHS with a performance guarantee shall include, but not be limited to:

2.16.7.6.2.1. The Contractor's net worth, as determined by EOHHS, falls below 133% of EOHHS's Insolvency Reserve Requirement; or

2.16.7.6.2.2. The Contractor's liquidity ratio, as determined by EOHHS, falls below 1.5.

2.16.7.6.3. Performance guarantees must include:

2.16.7.6.3.1. A promissory note from the Contractor's parent(s) or a performance bond from an independent agent in the amount of seven percent (7%) of EOHHS's Insolvency Reserve Requirement to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's impending or actual insolvency; and

2.16.7.6.3.2. A promissory note from the Contractor's parent(s) or a performance bond from an independent agent in the amount of three percent (3%) of EOHHS's Insolvency Reserve Requirement 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.

2.16.8. Auditing and Other Financial Requirements

2.16.8.1. The Contractor shall:

2.16.8.1.1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits shall comply with the following requirements and shall be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards:

2.16.8.1.1.1. No later than one hundred and twenty (120) days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS the 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):

2.16.8.1.1.1.1. If directed by EOHHS, the Contractor shall produce financial statements for specific lines of business, other Medicaid products, and other Medicare products.

2.16.8.1.2. 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 a Service Organization Controls report (SOC1 report) from its independent auditor on the effectiveness of the internal controls over operations of the Contractor, specific 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.

2.16.8.1.3. The Contractor shall submit, on an annual basis after each annual audit, the final audit report specific to this Contract, together with all supporting documentation, a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

2.16.8.1.4. Utilize a methodology to estimate Incurred But Not Reported (IBNR) claims adjustments for each Rating Category and annually provide to EOHHS a written description of the methodology utilized in the preparation of the Contractor's audited financial statements to estimate IBNR claims adjustments for each Rating Category. The Contractor shall provide EOHHS with the lag triangles and completion factors used in the development of the quarterly financial reports in

accordance with reporting timelines in **Appendix A**. The Contractor shall submit its proposed IBNR methodology to EOHHS for review and approval and, as directed by EOHHS, shall modify its IBNR methodology in whole or in part;

2.16.8.1.5. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify the Contractor's Governing Board of the potential for insolvency;

2.16.8.1.6. Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract;

2.16.8.1.7. Advise EOHHS no later than thirty (30) calendar days prior to execution of any significant organizational changes, new Material Subcontracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract;

2.16.8.1.8. Not invest funds in, or loan funds to, any organization in which a director or principal officer of the Contractor has a financial interest; and

2.16.8.1.9. Maintain detailed documentation of all asset and liability transactions reflected in the SCO Plan's balance sheet, that are between the Contractor and any affiliate, parent organization, subsidiary, or other related entity, as appropriate. The Contractor shall disclose this information as requested by EOHHS.

2.16.9. Provider Risk Arrangements

2.16.9.1. To the extent permitted by law, the Contractor may enter into arrangements with Providers that place Providers at risk subject to the following limitations:

2.16.9.1.1. No incentive arrangement may include specific payments as an inducement to withhold, limit, or reduce services to Enrollees.

2.16.9.1.2. The Contractor shall remain responsible for assuring that it complies with all of its obligations under the Contract including, but not limited to, access standards, providing all Medically Necessary SCO Covered Services, including Medicare services and Supplemental Benefits, services described in **Appendix C**, Flexible Benefits pursuant to the Enrollee's Care Plan, including consideration of value and outcomes as described in **Section 2.10.11**, quality, and health equity.

The Contractor shall monitor Providers who are at risk to assure that all such requirements are met and shall terminate or modify such arrangements if necessary.

2.16.9.1.3. The Contractor shall disclose these arrangements including all contracts, appendices and other documents describing these arrangements, to EOHHS as follows:

2.16.9.1.3.1. As a part of Readiness Review;

2.16.9.1.3.2. As requested by EOHHS; or

2.16.9.1.3.3. If there are any changes in its risk arrangements with any 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.

2.16.10. Right to Audit and Inspect Books

2.16.10.1. The Contractor shall provide EOHHS, the Secretary of the U.S. Department of Health and Human Services, and their designees its books and records for audit and inspection of:

2.16.10.1.1. The Contractor's capacity to bear the risk of potential financial losses;

2.16.10.1.2. Services performed or the determination of amounts payable under the Contract;

2.16.10.1.3. Rates and payments made to Providers for each service provided to Enrollees; and

2.16.10.1.4. Financial data and Encounter Data, and related information, including but not limited to such data and information needed for EOHHS to conduct audits for any Contract Year in accordance with 42 CFR 438.602(e).

2.16.11. Other Information

2.16.11.1. The Contractor shall 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. Such information shall include, but not be limited to, the revenue, expenses and utilization reports set forth in **Appendix A**, and the outstanding litigation report set forth in **Appendix A**.

2.16.12. Reporting

2.16.12.1. The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 2.16** and **Appendix A**, in accordance with specified timetables, definitions, formats, assumptions, and certifications, as well as any ad hoc financial reports required by EOHHS.

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

2.16.13. FIDE SNP Medicare Advantage Bid

2.16.13.1. No later than five (5) weeks prior to the deadline for submission of the annual Medicare Advantage bid submission (i.e., thirty-five (35) calendar days prior to the first Monday in June), the Contractor shall submit to EOHHS a report describing the Contractor's anticipated Medicare rebate amount, including an accounting of the build-up and underlying assumptions, for the Contract Year covered in the bid submission and cost sharing. The Contractor shall provide additional information regarding its bid submission as requested by EOHHS.

2.16.13.2. This report shall include a written proposal and accompanying analysis demonstrating how the Contractor intends to use the available rebate amount. If cost sharing is set above zero, then the report shall include an explanation of why the plan seeks to set cost sharing above zero.

2.16.13.3. No later three (3) business days following the Medicare bid submission for each Contract Year, the Contractor shall provide to EOHHS the Contractor's annual Medicare Advantage bid submission to CMS; the Contractor shall also provide any subsequent bid adjustments or resubmissions to EOHHS within three (3) business days of the submission to CMS.

2.16.13.4. No later than ten (10) business days following CMS approval of the Contractor's annual bid submission, the Contractor shall submit to EOHHS a copy of its final Medicare Advantage bid, final rebate amounts and allocations, and notice of CMS approval.

2.17. Benefit Coordination

2.17.1. General Requirements

2.17.1.1. Coordination of Benefits

2.17.1.1.1. EOHHS shall, via the HIPAA 834 Outbound Enrollment file, provide the Contractor with all third-party health insurance information on Enrollees where it has verified that third party health insurance exists.

2.17.1.1.2. EOHHS shall refer to the Contractor the Enrollee's name and pertinent information where EOHHS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

2.17.1.2. The Contractor shall:

2.17.1.2.1. Designate a third-party liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.

2.17.1.2.2. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

2.17.1.2.3. Perform Benefit Coordination in accordance with this **Section 2.17.1**. The Contractor shall work with EOHHS via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

2.17.1.3. Third Party Health Insurance Information:

2.17.1.3.1. The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance except Medicare Part A and B and MassHealth Standard and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

2.17.1.3.1.1. The HIPAA 834 Outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see **Appendix J**);

2.17.1.3.1.2. Claims Activity;

2.17.1.3.1.3. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and

2.17.1.3.1.4. Any TPL information self-reported by an Enrollee.

2.17.1.4. At a minimum, such procedures shall include:

2.17.1.4.1. If the Contractor also offers commercial policies or a Qualified Health Plan offered through the Exchange, the Contractor shall perform a match within their own commercial plan or Qualified Health Plan offered through the Exchange. If an Enrollee is found to also be enrolled

in the Contractor's commercial plan or a Qualified Health Plan offered through the Exchange, the Enrollee's information shall be sent to EOHHS or a designee assigned by EOHHS. EOHHS shall verify the Enrollee's enrollment and eligibility status and if EOHHS confirms that the Contractor was correct, disenroll the Enrollee retroactive to the effective date of other insurance.

2.17.1.4.2. Reviewing claims for indications that other insurance may be active (e.g., explanation of benefit attachments or third-party payment).

2.17.2. Third Party Health Insurance Cost Avoidance, Pay and Recover Later and Recovery

2.17.2.1. Once an Enrollee is identified as having other health insurance, the Contractor shall cost avoid claims for which another insurer may be liable, except in the case of prenatal services per 42 U.S.C. 1396(a)(25)(E) and 42 C.F.R. § 433.139.

2.17.2.2. The Contractor shall perform the following activities to cost avoid, pay, and recover later, or recover claims when other health insurance coverage is available:

2.17.3. Cost Avoidance

2.17.3.1. The Contractor shall:

2.17.3.1.1. On the Daily Inbound Demographic Change File provide all third-party liability information on the Contractor's Enrollees;

2.17.3.1.2. Pend claims that are being investigated for possible third-party health insurance coverage in accordance with EOHHS's guidelines;

2.17.3.1.3. Deny claims submitted by a provider when the claim indicates the presence of other health insurance;

2.17.3.1.4. Instruct providers to use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and

2.17.3.1.5. Distribute TPL Indicator Forms at the Contractor's provider orientations.

2.17.4. Pay and Recover Later

2.17.4.1. The Contractor shall take all actions necessary to comply with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139.

2.17.5. Recovery

2.17.5.1. The Contractor shall:

2.17.5.1.1. Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;

2.17.5.1.2. Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and

2.17.5.1.3. Develop procedures and train staff to ensure that Enrollees who have comprehensive third-party health insurance are identified and reported to EOHHS.

2.17.6. Reporting

2.17.6.1. Semiannually, the Contractor shall report to EOHHS the following, in accordance with the requirements set forth in **Appendix A**:

2.17.6.1.1. Other Insurance – the number of referrals sent by the Contractor on the Inbound Demographic Change File, and the number of Enrollees identified as having TPL on the monthly HIPAA 834 Inbound Enrollment file;

2.17.6.1.2. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139;

2.17.6.1.3. Cost avoidance – the number and dollar amount of claims that were denied by the Contractor due to the existence of other health insurance coverage on a semiannual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

2.17.6.1.4. Recovery Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semiannual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or provider.

2.17.7. Accident and Trauma Identification and Recovery Identification

2.17.7.1. Cost Avoidance and Recovery

2.17.7.1.1. The Contractor shall recover, or cost avoid claims where an Enrollee has been involved in an accident or lawsuit in accordance with **Appendix A**.

2.17.8. Claims Editing and Reporting

2.17.8.1. The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third-party liability cases:

2.17.8.1.1. Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

2.17.8.1.2. Provider Notification – Claims where providers have noted accident involvement;

2.17.8.1.3. Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident; and

2.17.8.1.4. Questionnaires will be based on a predetermined diagnosis code range.

2.17.9. Medical Management

2.17.9.1. The Contractor shall identify any requested medical services related to motor vehicle accidents, or work-related injuries, and refer these claims to the recoveries specialist for further investigation.

2.17.10. Reporting

2.17.10.1. On a semiannual basis, the Contractor will provide EOHHS with cost avoidance and recovery information on accidents and trauma cases as specified in Appendix A.

2.17.11. No Third-Party Enforcement

2.17.11.1. No person not executing this Contract shall be entitled to enforce this Contract against a party hereto regarding such party’s obligations under this Contract.

3 EOHHS Responsibilities

3.1. Contract Management

3.1.1. Administration of FIDE SNP

3.1.1.1. EOHHS shall:

3.1.1.1.1. Designate a contract manager from EOHHS that is authorized and empowered to represent EOHHS about all aspects of the Contract. EOHHS's contract manager shall act as a liaison between the Contractor and EOHHS during the Contract Term; and

3.1.1.1.2. Coordinate a Contract Management Team (CMT) that shall, at EOHHS's discretion and to facilitate joint State/CMS Oversight pursuant to 42 CFR 422.107(e), include at least one (1) representative from CMS.

3.1.1.2. Joint State/CMS Oversight shall include, but not be limited to, EOHHS and CMS sharing with each other relevant plan information, coordinating on program audits, and consulting on network exception requests

3.1.1.3. At EOHHS direction and discretion, contract management, administration, monitoring, and oversight activities shall be conducted through direct electronic submission of materials to EOHHS, coordinated with CMS reviews, and when specified, shall be via submissions in CMS' Health Plan Management System (HPMS) (or its successor), as indicated in 42 CFR 422.107(e)(3).

3.1.1.4. EOHHS shall coordinate with CMS to create, edit, and provide through HPMS integrated material templates and instructions specific to operating a Massachusetts SCO Plan.

3.1.2. Oversight

3.1.2.1. EOHHS shall, through both its contract manager and the CMT:

3.1.2.1.1. Monitor compliance with the terms of the Contract;

3.1.2.1.2. Receive and respond to all inquiries and requests made by the Contractor under this Contract;

3.1.2.1.3. Meet with the Contractor's representative and leadership on a periodic or ad hoc basis for regular monitoring, performance and contract management;

3.1.2.1.4. Coordinate with the Contractor, as appropriate, on Contractor requests for technical assistance or coordination on Contractor responsibilities;

3.1.2.1.5. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, EOHHS, or in consultation with CMS;

3.1.2.1.6. At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data;

3.1.2.1.7. Inform the Contractor of any discretionary action by EOHHS under the provisions of the Contract;

3.1.2.1.8. Review, approve (including providing feedback or direction on issues needing resolution prior to approval), otherwise monitor, and coordinate with CMS as needed regarding the Contractor's:

3.1.2.1.8.1. Marketing, Outreach, education, and orientation materials and procedures, and all Member other Member facing communications and materials;

3.1.2.1.8.2. Grievance and Appeals data and procedures;

3.1.2.1.8.3. Denials, including Prior Authorization and Utilization Management processes, criteria, and related policies; and

3.1.2.1.9. Receive and respond to incidents and or complaints;

3.1.2.1.10. Monitor compliance with all applicable rules and requirements, and issue compliance notices and other compliance actions, as appropriate; and

3.1.2.1.11. Sanction, under **Section 5.4**, if it determines that the Contractor is in violation of any of the terms of the Contract.

3.1.2.2. At its discretion, EOHHS shall conduct periodic audits and surveys of the Contractor, as described under **Section 5.5**, including through on-site and/or virtual visits as determined necessary by EOHHS to verify the accuracy of reported data.

3.1.2.2.1. At the time of such visits, the Contractor shall assist EOHHS in activities pertaining to an assessment of all facets of the SCO Plan's operations including, but not limited to, financial, administrative, clinical, utilization and Network Management, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein; and

3.1.2.3. If it determines that the Contractor is out of compliance with **Section 5.1.6** of the Contract, EOHHS shall notify the Secretary of such non-compliance and determine the impact on the term of the Contract in accordance with **Section 5.6** of the Contract; and

3.1.2.4. 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 2.9**.

3.1.3. Performance Evaluation

3.1.3.1. EOHHS shall, at its discretion, including in coordination with CMS:

3.1.3.1.1. Annually review the impact and effectiveness of the Quality Management/Quality Improvement program by reviewing the results of performance improvement projects, performance on standard measures, and all other quality initiatives specified in **Section 2.14**.

3.1.3.1.2. 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 2.15 and 2.16**, and the performance measurement and performance improvement projects set forth in **Section 2.14** and **Appendix B**, and shall at its discretion, monitor and evaluate any or all of the Contractor's operational processes and metrics that indicate the Contractor's organizational health. EOHHS will provide the Contractor with the written results of these evaluations, including in coordination with CMS if applicable, including, at its discretion, feedback on how the Contractor has performed relative to its own historical performance and relative to other managed care plans, Massachusetts FIDE SNP plans, the other SCO plans, or other appropriate benchmarks.

3.1.3.1.3. Conduct periodic audits of the Contractor, as further described in **Section 5.4**, including, but not limited to, annual External Quality Review Activities, as specified in **Section 2.14.4** and an annual operational review site visit or virtual visit pursuant to **Section 3.1.2.2**;

3.1.3.1.4. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and

3.1.3.1.5. Evaluate, in conjunction with the U.S. Department of Health and Human Services, through inspection or other means, the quality, appropriateness, and timeliness of services performed by the Contractor and all Network Providers.

3.1.3.1.6. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.2. Enrollment and Disenrollment Systems

3.2.1. EOHHS will provide to the Contractor:

3.2.1.1. Enrollment and disenrollment responses and transactions, including to the Contractor as applicable, via the HIPAA 834 Outbound Daily Enrollment file, which will be updated on a daily (business day) basis and provided on each business day of the Contract Year, and through HIPAA 834 monthly files;

3.2.1.2. Rating Category determinations and Medicaid risk adjustment scores, including to the Contractor, as applicable; and

3.2.1.3. Continuous verification of eligibility status, through the Eligibility Verification System (EVS) and through the HIPAA 834 Outbound Daily Enrollment file.

3.3. Outreach, Marketing, and Education Monitoring

3.3.1. The Contractor shall use required Outreach, Marketing, and Education materials that integrate Medicare and Medicaid content as specified, reviewed, and approved by EOHHS pursuant to 42 CFR 422.107(e)(1)(ii), **Section 2.12**, and as further described below.

3.3.2. EOHHS shall monitor the Contractor's Outreach, Marketing, and Education activities and distribution of related materials on an ongoing basis, including through:

3.3.2.1. Review and approval of all such materials, which shall be required prior to use, unless otherwise authorized by EOHHS;

3.3.2.2. Random on-site review of Outreach, Marketing, and Education forums, products, and activities;

3.3.2.3. Random review of actual Outreach, Marketing, and Education pieces as they are used in or by the media;

3.3.2.4. For-cause review of Outreach, Marketing, and Education materials and activities when complaints are made by any source; and

3.3.3. If EOHHS finds that the Contractor is violating these requirements, EOHHS may issue and sanction and shall monitor the development and implementation of a corrective action plan.

3.3.4. EOHHS shall coordinate such monitoring activities with CMS as applicable, and, as described in **Section 2.12**.

4 Payment and Financial Provisions

4.1. SCO Rating Categories and Assignment

4.1.1. Assignment

4.1.1.1. EOHHS will assign each Enrollee to a Rating Category according to the individual Enrollee's clinical, functional, and demographic status and setting of care, using the criteria described in **Section 4.1.2**.

4.1.1.2. Notwithstanding the provision below requiring submission of an MDS-HC, EOHHS may make temporary Rating Category assignments using other available data sources pending the Contractor's timely submission of a completed MDS-HC or MDS 3.0.

4.1.1.3. EOHHS may propose modifications, additions, or deletions to the Rating Categories over the course of the Contract. EOHHS shall inform the Contractor of such changes to the Rating Categories in writing, and the Contractor shall accept such changes.

4.1.2. Rating Categories

4.1.2.1. SCO Rating Categories are grouped into Community Rating Categories (Community NHC, BH, and Other) and Facility Rating Categories (Institutional Tiers 1, 2, and 3); Enrollees will be temporarily assigned to a Transition Rating Category (Transition to Institution or Transition to Community) when moving between community and nursing facility settings.

4.1.2.2. Community Nursing Home Certifiable (NHC)

4.1.2.2.1. Enrollees will be classified as Nursing Home Certifiable if they do not meet criteria for a Facility or a Transition Rating Category, they reside in the community, and they meet clinical eligibility criteria for Nursing Facility services (see CMR 456.409), indicated through the assessment described in **Section 2.5.2** (MDS-HC assessment) and as approved by EOHHS.

4.1.2.3. Community Behavioral Health (BH)

4.1.2.3.1. Enrollees will be classified as Community Behavioral Health if they do not meet criteria for a Facility or a Transition Rating Category, or the Community NHC Rating Category, and their most recent MDS-HC assessment indicates one (1) or more of the Behavioral Health diagnoses listed below (using ICD-10), reflecting an ongoing condition such as schizophrenia or episodic mood disorder, psychosis, or alcohol or drug dependence not in remission. Diagnoses shall be confirmed in medical records and be chronic and ongoing.

4.1.2.3.1.1. F10.2- F10.29, excluding F10.21 (SUD – Alcohol Dependence)

4.1.2.3.1.2. F11.2- F11.29, excluding F11.21 (SUD – Opioid Dependence)

4.1.2.3.1.3. F12.2- F12.29, excluding F12.21 (SUD – Cannabis Dependence

4.1.2.3.1.4. F13.2- F13.29, excluding F13.21 (SUD - Sedative, Hypnotic, or Anxiolytic-related Dependence)

4.1.2.3.1.5. F14.2- F14.29, excluding F14.21 (SUD – Cocaine Dependence)

4.1.2.3.1.6. F15.2- F15.29, excluding F15.21 (SUD – Other Stimulant Dependence)

4.1.2.3.1.7. F16.2- F16.29, excluding F16.21 (SUD – Inhalant Dependence)

4.1.2.3.1.8. F18.2- F18.29, excluding F18.21 (SUD – Other Psychoactive Substance Dependence)

4.1.2.3.1.9. F19.2- F19.29, excluding F19.21 (SUD)

4.1.2.3.1.10. F20- F20.9, F25 F25.9 (schizophrenia)

4.1.2.3.1.11. F28, F29 (other psychosis, other psychotic disorder not due to a substance or known physiological condition)

4.1.2.3.1.12. F30- F30.9 (bipolar – Manic Episode)

4.1.2.3.1.13. F31- F31.9 (bipolar – Bipolar Disorder)

4.1.2.3.1.14. F32- F32.9 (major depression – Depressive Episode)

4.1.2.3.1.15. F33- F33.9 (major depression – Major Depressive Disorder, Recurrent)

4.1.2.3.1.16. F34.8, F34.9, F39 (mood disorders – Persistent Mood (Affective) Disorders)

4.1.2.4. Community Other

4.1.2.4.1. Enrollees will be classified as Community Other if they do not meet criteria for a Facility or a Transition Rating Category, or for the Community NHC or the Community BH Rating Categories.

4.1.2.4.2. For all MDS-HC submissions that do not meet criteria for Community NHC or Community BH, the Enrollee will default to the Community Other Rating Category.

4.1.2.5. Institutional Tier 1

4.1.2.5.1. Enrollees will be classified as Institutional Tier 1 if they have more than a three (3) month consecutive stay in an institutional long-term care setting, continue to reside in a nursing facility, and are classified into Patient Driven Payment Model (PDPM) nursing groups O, Q,S,W or Y;

4.1.2.6. Institutional Tier 2

4.1.2.6.1. Enrollees will be classified as Institutional Tier 2 if they have more than a three (3) month consecutive stay in an institutional long-term care setting, continue to reside in a nursing facility, and are classified into PDPM nursing groups C, F, G, J, N, P, R, V, or X; and

4.1.2.6.2. The Contractor will also be reimbursed at the Institutional Tier 2 rate for nursing facility residents who have elected hospice and who have resided in a nursing facility for more than three months.

4.1.2.7. Institutional Tier 3

4.1.2.7.1. Enrollees will be classified as Institutional Tier 3 if they have more than a three (3) month consecutive stay in an institutional long-term care setting, continue to reside in a nursing facility, and are classified into PDPM nursing groups A, B, D, E, H, I, L, M, T, or U.

4.1.2.8. Transition to Institution

4.1.2.8.1. Enrollees who are in the first three months of a nursing facility stay due to a change in status from a community setting will move from their community Rating Category into the Transition to Institution Rating Category, which is based on the Community NHC rate range, effective the first full calendar month of their admission. Enrollees that remain in the nursing facility will move to the appropriate Institutional Rating Category after three months.

4.1.2.9. Transition to Community

4.1.2.9.1. Enrollees who are in the first three (3) months of living in the community will move from their Institutional Rating Category into the Transition to Community Rating Category, which is based on the Institutional Tier 1 rate range, effective the first full calendar month of their discharge from the nursing facility. Enrollees that remain in a

community setting will move to the appropriate Community Rating Category after three months.

4.2. Payment Methodology and Terms

4.2.1. Payment for FIDE SNP with Exclusively Aligned Enrollment

4.2.1.1. The Contractor shall receive monthly capitation payments from EOHHS and from Medicare for each Dual Eligible Enrollee.

4.2.1.2. To obtain payment from Medicare for Dual Eligible Enrollees, the Contractor shall comply with Medicare Advantage and Medicare Part D requirements, including as required pursuant to its Medicare Advantage D-SNP Contract with CMS.

4.2.2. Medicaid Payment for Enrollees

4.2.2.1. EOHHS will make monthly Medicaid payments to the Contractor for each Dual Eligible Enrollee for the Covered Services and activities described in this Contract, in accordance with the Rating Categories described in **Section 4.1.2**, the payment provisions set forth in this **Section 4**, the Base Capitation Rates and payment provisions contained in **Appendix D**, and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended.

4.2.2.2. EOHHS may further apply additional adjustments to the Base Capitation Rates (e.g., risk adjustment, Quality Withholds, Alternative Payment Methodologies, or other adjustments described in this **Section 4**), in calculating monthly capitation payments.

4.2.2.3. EOHHS will make monthly, prospective capitation payments to the Contractor. EOHHS will categorize Enrollees by Rating Category according to the process outlined in **Section 4.1.2**. The Medicaid monthly capitation payment for each Rating Category and Region will be the product of the number of Eligible Enrollees in each Rating Category in each Region, multiplied by the payment rate for that Rating Category and Region, and further risk adjusted for that Rating Category and Region, as applicable. Enrollee Contribution to Care amounts will be deducted from the total Medicaid monthly capitation payment amount, in accordance with **Section 4.2.3**.

4.2.3. Base Capitation Rates

4.2.3.1.1. In accordance with 42 CFR 438.4, beginning on the Contract Operational Start Date, Base Capitation Rates for each Rating Category and Region in the Contractor’s Service Area shall be Actuarially Sound Capitation Rates.

4.2.3.2. These Base Capitation Rates shall be set for each Massachusetts County in which SCO is offered. EOHHS may roll up Counties to Regions for rate setting purposes.

4.2.3.3. Base Capitation Rates shall be incorporated into the Contract in **Appendix D**.

4.2.3.4. The Base Capitation Rate shall reflect the applicable cost of Administrative Services, underwriting gain, care management, all Medicaid services (including Medicaid cost-sharing and Medicaid-primary services), and any non-medical costs not otherwise paid for under the Contract, including but not limited to activities related to advancing Health Equity.

4.2.4. Risk Adjusted Capitation Rates

4.2.4.1. EOHHS may apply risk adjustment to the Base Capitation Rates. Such risk adjustment shall be based on an aggregation of the individual risk profiles of SCO Enrollees, using a risk adjustment methodology to be developed.

4.2.4.2. The Contractor shall accept as payment in full such Risk Adjusted Capitation Rates.

4.2.5. Modifications to Capitation Rates

4.2.5.1. Base Capitation Rates will be updated for January 1st of each calendar year, and as otherwise indicated by EOHHS. EOHHS shall meet with the Contractor annually, upon request, to announce and explain the Base Capitation Rates for the upcoming calendar year.

4.2.5.2. EOHHS will notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in **Section 4.6**.

4.2.5.3. Prior to the beginning of the Contract Year, EOHHS shall incorporate, by amendment, the Base Capitation Rates by Rating Category and by Region into the Contract at **Appendix D**.

4.2.5.4. Prior to the beginning of the Contract Year, the Contractor shall accept the Base Capitation Rates for the new Contract Year as follows:

4.2.5.4.1. In writing, in a form and format specified by EOHHS, by a deadline specified by EOHHS that allows sufficient time for EOHHS to load such Base Capitation Rates into EOHHS's payment system.

4.2.5.4.2. Prior to the beginning of the Contract Year, by executing an amendment to the Contract incorporating the new Base Capitation Rates, as described above.

4.2.5.5. EOHHS may amend the Base Capitation Rates at such other times as may be necessary as determined by EOHHS, or as a result of changes in federal or state law, including but not limited to, to account for changes in SCO participation requirements, SCO Covered Services, or primary payer assignment between Medicare and Medicaid.

4.2.6. Timing of Capitation Payments

4.2.6.1. EOHHS shall make monthly per Member per month capitation payments to the Contractor. The PMPM capitation payment for a particular month will reflect payment for the Enrollees with effective enrollment into the Contractor's SCO Plan as of the first day of that month, as described in **Section 2.4**.

4.2.6.2. The final per Member per month capitation payment made by EOHHS to the Contractor for each Enrollee shall be for the month in which the disenrollment was submitted in accordance with **Section 2.4**, the Enrollee loses eligibility (i.e., the month in which the Enrollee's last day of eligibility occurs).

4.2.7. Enrollee Contribution to Care Amounts

4.2.7.1. If, in the financial eligibility process conducted by EOHHS, an Enrollee residing in a nursing facility is determined to owe a monthly Enrollee-paid amount, such amounts are the Enrollee's contribution to care. At the time of enrollment, and as adjusted thereafter, EOHHS will advise the Contractor of the amount of the Enrollee's contribution to care. When an Enrollee contribution to care is established, 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 N**).

4.2.8. Indian Enrollees and Indian Health Care Providers

4.2.8.1. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. See also 42 C.F.R. § 438.14;

4.2.8.2. The Contractor shall offer Indian Enrollees the option to choose an Indian health care provider as a PCP if the Contractor has an Indian PCP in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain Covered Services from non-network Indian Health Care Providers from whom the Enrollee is

otherwise eligible to receive such services. The Contractor shall also permit a non-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider;

4.2.8.3. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Covered Services for Indian Enrollees;

4.2.8.4. The Contractor shall pay both network and non-network Indian Health Care Providers or I/T/U who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth Fee-For-Service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian Health Care Provider or I/T/U or the MassHealth Fee-For-Service rate for the same service, whichever is greater;

4.2.8.5. The Contractor shall make prompt payment to Indian Health Care Providers;

4.2.8.6. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 C.F.R. § 438.14(c)(1); and

4.2.8.7. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider, Indian Health Service, an I/T/U or through referral under contract health services. The Contractor shall exempt from all cost sharing any Indian Enrollee who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

4.2.9. One-time Seventy-Two (72) Hour Medication Supply

4.2.9.1. In accordance with 130 CMR 406.414(c), if a pharmacist cannot bill Contractor at the time an Enrollee presents the pharmacist with a prescription for a MassHealth covered medication and MassHealth pays for a one-time seventy-two (72) hour supply of the prescribed medications, the Contractor shall reimburse MassHealth for such sum, as set forth in **Section 2.10.7.9**.

4.2.10. Delivery of Medications

4.2.10.1. The Contractor shall reimburse pharmacy providers for delivery of medications to a personal residence (including homeless shelters) at a rate no less, and in a manner no more restrictive, than EOHHS uses in its Fee-For-Service program.

4.2.11. Federally Qualified Health Centers (FQHC)

4.2.11.1. 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 EOHHS would pay for such services on a Fee-For-Service basis as specified in 101 CMR 304.04, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

4.2.12. Loss of Program Authority

4.2.12.1. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor shall do no work on that part after the effective date of the loss of program authority. EOHHS shall adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If EOHHS or CMS paid the Contractor in advance to work on a no longer authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS or CMS, respectively. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS or CMS included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

4.3. Transitions Between Rating Categories

4.3.1. Transition between Rate Cells

4.3.1.1. Capitation Rates will be updated following a change in an Enrollee’s status, based on the Rating Category Assessment tool proscribed by EOHHS (MDS-HC or MDS 3.0) and the Status Change Form (SC-1) for

Nursing Facility Residents, or any subsequent forms required by EOHHS. The MassHealth transition rules are as follows:

4.3.1.1.1. Institutional to Community Rating Categories

4.3.1.1.1.1. For a transition from an institutional Rating Category into a community Rating Category, the rate change to the appropriate community Rating Category will become effective on the first calendar day of the month following ninety (90) calendar days after discharge.

4.3.1.1.2. Between Community Rating Categories

4.3.1.1.2.1. For a transition between community Rating Categories, if the MDS-HC form is received and approved on or before the last day of the month, the rate change will become effective on the first calendar day of the following month.

4.3.1.1.3. Between Institutional Rating Categories

4.3.1.1.3.1. For a transition between institutional Rating Categories, the rate change will become effective on the first calendar day of the month after the MDS 3.0 is received and approved by EOHHS.

4.3.1.1.4. Community to Institutional Rating Categories

4.3.1.1.4.1. For a transition from one of the community Rating Categories into an institutional Rating Category (Tier 1, 2, or 3), If the Enrollee has not been discharged after 90 calendar days, the rate will change to the appropriate institutional Rating Category (Tier 1, 2, or 3) on the first day of the month following 90 calendar days after admission.

4.3.2. Audits/Monitoring

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

4.4. Reconciliation

4.4.1. Enrollment and Rating Category Reconciliations

4.4.1.1. EOHHS shall implement a process to reconcile enrollment and capitation payments for the Contractor that will take into consideration the following circumstances:

4.4.1.1.1. Transitions between Rating Categories;

4.4.1.1.2. Retroactive changes in eligibility, Rating Categories, or Enrollee contribution amounts; and

4.4.1.1.3. Changes through new enrollment, disenrollment, or death.

4.4.1.2. EOHHS shall perform a quarterly reconciliation of the monthly capitation payments and other under- or overpayments identified through audits described in **Section 4.3.2**, as described below:

4.4.1.2.1. Calculate the correct EOHHS payment of the Capitation Rate for each month per Enrollee by determining the Enrollee's appropriate Rating Category and the appropriate Enrollee contribution, as well as enrollment and eligibility status; and

4.4.1.2.2. Reconcile the monthly EOHHS Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate.

4.4.1.2.3. Reconciliation for the EOHHS payment may also occur based on a longer and/or older prior periods as appropriate and necessary.

4.4.1.3. The reconciliation may identify underpayments or overpayments to the Contractor.

4.4.1.3.1. EOHHS shall remit to the Contractor the full amount of any underpayment it identifies.

4.4.1.3.2. The Contractor shall remit to EOHHS within sixty (60) calendar days the full amount of any overpayments or other payments in excess of amounts specified in the Contract identified by EOHHS pursuant to **Section 4.4**. Such payment shall be made either through a check or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.

4.4.2. Family Planning Services Reconciliation Process

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

4.4.2.1.1. Calculate all FFS claims paid by EOHHS for family planning services, including family planning pharmacy services, provided to Enrollees each CY; and

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

4.4.3. Continuing Services Reconciliation.

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

4.4.3.1.1. The Contractor shall process and pay its providers' claims for all Continuing Services at the Contractor's contracted rate with its providers;

4.4.3.1.2. EOHHS shall perform a reconciliation by June 30th, following the end of the CY to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by the BOH and which were provided following the conclusion of the final internal Appeal ("approved Continuing Service claims"), provided that the Contractor submits to EOHHS by March 31st, following the end of the CY, all data regarding such services as required in **Section 4.4.3.2**; and

4.4.3.1.3. EOHHS shall pay the Contractor no later than twelve (12) months following the end of the CY being reconciled, the total value of the approved Continuing Service claims referenced in **Section 4.4.3.2** that were provided within the applicable CY, provided the Contractor timely submitted all data required by EOHHS pursuant to this **Section 4.4.3.2**.

4.4.3.2. Approved Continuing Service claims shall include, at a minimum, the following information:

4.4.3.2.1. Enrollee information by MassHealth identification number, including Medicare identification number, date of birth, sex, dates of enrollment, the date on which the Continuing Services were provided, and current enrollment status;

4.4.3.2.2. Costs incurred, by MassHealth identification number, and Medicare identification number, including date of service;

4.4.3.2.3. Such other information as may be required pursuant to any EOHHS request for information;

4.4.3.2.4. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Enrollee by the Contractor; and

4.4.3.2.5. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided in this **Section 4.4**.

4.4.4. Claims Leakage

4.4.4.1. As further specified by EOHHS, EOHHS shall perform periodic reconciliations for payments made by EOHHS on a fee-for-service basis for claims for Covered Services provided to Enrollees. EOHHS shall identify through such reconciliations the amount owed to EOHHS by the Contractor. The Contractor shall remit to EOHHS the full amount through recoupment from future capitation payments or by other payment mechanisms, including direct reimbursement, as determined by EOHHS.

4.5. Risk Corridors

4.5.1. Risk corridors shall be established for Contract Years 1 through 5.

4.5.2. General Provisions

4.5.2.1. Calculation of Gains and Losses

4.5.2.1.1. The risk sharing arrangement described in this **Section 4.5** of the Contract may result in payment by EOHHS to the Contractor or by the Contractor to EOHHS.

4.5.2.1.2. All payments to be made by EOHHS to the Contractor or by the Contractor to EOHHS will be calculated and determined by EOHHS.

4.5.2.1.3. All calculations, determined by EOHHS, will be based on the Contractor's reporting of Actual and Adjusted Medical Expenditures, as required in **Section 4.5.4** below. All reporting will be subject to review and/or audit at EOHHS's discretion.

4.5.2.1.4. EOHHS will perform settlements of the payments made by the Contractor to EOHHS, or by EOHHS to the Contractor, as described in **Section 4.5.4** below.

4.5.2.2. Allowable Expenditures

4.5.2.2.1. EOHHS shall use Encounter Data, cost data, and financial reporting data submitted by the Contractor (as required by **Section 4.5.4** below and **Sections 2.15** – **2.17** of this Contract) to account for financial adjustments to Actual Medical Expenditures as needed to determine Adjusted Medical Expenditures. EOHHS reserves the right to audit Actual and Adjusted Medical Expenditure data.

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

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

4.5.2.2.3. EOHHS reserves the right to adjust expenditures for services that are reimbursed at more than five (5%) percent above the average reimbursement rate of all SCO Plans. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against EOHHS for a determination to adjust or a failure to adjust expenditures for services of any SCO Plan.

4.5.3. Risk Sharing Arrangement for the Contract Year

4.5.3.1. For all Rating Categories, the Contractor and EOHHS shall share risk on Adjusted Medical Expenditures, by calculating the difference between the medical component of Capitation Rate Payments, inclusive of risk adjustment (if applicable) and assuming the Contractor received the full quality withhold payment and Adjusted Medical Expenditures in accordance with the following provisions.

4.5.3.2. Risk sharing shall be calculated using a tiered Contractor-level symmetrical risk corridor to include all Adjusted Medical Expenditures relative to the medical component of Capitation Rate Payments, and as if the Contractor had received the full quality withhold payment.

4.5.3.3. EOHHS shall determine the Contractor's Adjusted Medical Expenditures in aggregate across all Rating Categories related to the provision of SCO Covered Services in **Appendix C** and Flexible Benefits as described in **Section 2.7.1** for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.4** below, and may verify such data in a manner it determines appropriate.

4.5.3.4. If the Contractor's Adjusted Medical Expenditures (as described in **Section 4.5.2.2**, and as determined by EOHHS in accordance with the above provisions across all Rating Categories) are greater than or less than the medical component of Capitation Rate Payments, EOHHS and the Contractor shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix E**.

4.5.3.5. EOHHS shall exclude from all calculations related to this risk sharing arrangement the Contractor's reinsurance premiums paid and recovery revenues received if the Contractor chooses to purchase reinsurance.

4.5.4. Risk Sharing Settlement

4.5.4.1. EOHHS shall determine settlement of payments made by the Contractor to EOHHS or by EOHHS to the Contractor under this **Section 4**. Settlement amounts shall be calculated for each Contract Year.

4.5.4.2. The settlement shall be based on twelve (12) months of claims runout, an Incurred But Not Reported (IBNR) estimate, and reported financials, except as described in **Section 4.5.4.4** below.

4.5.4.2.1. For the purpose of the settlement, the Contractor shall provide to EOHHS the following with its twelve (12) month run-out financial report (see **Appendix A**) for the applicable Contract Year:

4.5.4.2.1.1. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the Contract Year;

4.5.4.2.1.2. A complete and accurate report of Actual Medical Expenditures, based on category of services, for Enrollees based on claims incurred for the Contract Year, including twelve (12) months of claims runout;

4.5.4.2.1.3. The Contractor's best estimate of any claims incurred but not reported for claims runout beyond twelve (12) months and any IBNR completion factors by category of service;

4.5.4.2.1.4. A complete and accurate report of Part D revenue and expenditures, as required under 42 C.F.R. § 423.514(a)(1);

4.5.4.2.1.5. A complete and accurate report reflecting any Medicare reconciliations or recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Medical Expenditures, including those pursuant to coordination of benefits, third-party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in **Section 4.2.7**);

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

4.5.4.2.1.7. Financial Reports;

4.5.4.2.1.8. Encounter Data, as required under **Section 2.15.2** of this Contract, unless otherwise permitted by MassHealth; and

4.5.4.2.1.9. The Contractor shall provide any additional information upon request from EOHHS necessary to calculate Adjusted Medical Expenditures and Adjusted Non-Service Expenditures.

4.5.4.3. EOHHS shall provide the Contractor with a risk corridor reconciliation under the risk corridor arrangement within sixteen (16) calendar months following the end of each Contract Year. Any balance due between the Contractor and EOHHS shall be paid within sixty (60) days of the Contractor receiving the final risk corridor reconciliation from EOHHS.

4.5.4.4. EOHHS may open the reconciliation process in the event that Medicare Parts A and B Final Risk Adjustment is not finalized and included in the reports described in **Section 4.5.4.2** above, as provided in **Appendix E**.

4.5.4.5. The Contractor may request an earlier, interim settlement. EOHHS, at its sole discretion, may choose to make the settlement. If such an interim settlement is made:

4.5.4.5.1. The balance due for the final settlement shall be net of any payments made for the interim settlement, and shall be paid within sixty (60) days of the Contractor receiving such final reconciliation from EOHHS; and

4.5.4.5.2. For the final settlement, the parties shall comply with the requirements in this **Section 4.5.4**.

4.5.5. Medical Loss Ratio (MLR) Requirements

4.5.5.1. Medicaid MLR

4.5.5.1.1. 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 MLR) in accordance with 42 CFR 438.8.

4.5.5.1.2. The Contractor shall perform such Medicaid 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 MLR calculations for the prior calendar year to EOHHS in a form and format specified by EOHHS and as set forth in Appendix A. 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:

4.5.5.1.2.1. The Contractor shall calculate and report its Medicaid MLR as required in **Section 4.5.5.3** below, and in accordance with 42 CFR 438.8, as follows:

4.5.5.1.2.1.1. The numerator of the Contractor's Medicaid 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 shall be calculated in accordance with 42 CFR 438.8.

4.5.5.1.2.1.2. The denominator of the Contractor's Medicaid 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 shall be calculated in accordance with 42 CFR 438.8.

4.5.5.1.2.2. As further directed by EOHHS, the Contractor shall maintain a minimum Medicaid MLR of 85 percent in the aggregate for the Contractor's Enrollee population. If the Contractor does not maintain such minimum, the Contractor may, at EOHHS' discretion, pursuant to 42 CFR 438.8(j), 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 MLR numerator and the Medicaid MLR numerator that would have resulted in an 85% Medicaid MLR for the Contractor.

4.5.5.1.2.3. Calculation of the Contractor's Medicaid MLR for the purposes of determining whether the Contractor has maintained such minimum shall occur after any reconciliation under the risk sharing arrangement set forth in **Section 4.5.3.**

4.5.5.1.3. The Contractor shall require Material Subcontractors to which the Contractor delegates risk, as reported in accordance with **Appendix A**, to meet the MLR requirements set forth above and include such requirements in its subcontracts with its Material Subcontractors; provided, however that Material Subcontractor shall comply with the remittance requirement in **Section 4.5.5.1.2.2** above no later than one (1) year after the close of the Contract Year.. In addition:

4.5.5.1.3.1. The Contractor shall require that each Material Subcontractor report to the Contractor its MLR consistent with reporting requirements set forth in 42 CFR 438.8. The

Contractor shall submit such data to EOHHS in a form and format specified by EOHHS; and

4.5.5.1.3.2. The Contractor shall confirm to EOHHS, in a form and format specified by EOHHS, that its Material Subcontracts satisfy the requirements set forth in this Section.

4.5.5.2. Blended Medicare-Medicaid MLR:

4.5.5.2.1. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio (MLR) in the aggregate for all Covered Services (regardless of whether Medicare or Medicaid is the payor) for the Contractor's Enrollee population and individually for each Rating Category, in accordance with 42 CFR 438.8, and any additional guidance provided by EOHHS.

4.5.5.2.2. The Contractor shall report such MLR calculations for the prior calendar year in a form and format specified by EOHHS. The Contractor shall report such initial MLR calculations to EOHHS no later than July 31 of each year, or as otherwise directed by EOHHS, and shall report such final MLR calculations, which shall be refreshed to include subsequent reconciliations, to EOHHS by early December of each year, consistent with the due date for Medicare Advantage plans more generally, or as otherwise directed by EOHHS.

4.5.5.2.3. The Contractor shall calculate and report its Blended Medicare-Medicaid MLR as required in **Section 4.5.5.2** below, and in accordance with 42 CFR 438.8, as follows:

4.5.5.2.3.1. The numerator of the Contractor's Blended 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 shall be calculated in accordance with 42 CFR 438.8.

4.5.5.2.3.2. 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 shall be calculated in accordance with 42 CFR 438.8.

4.5.5.2.3.3. As further directed by EOHHS, the Contractor shall maintain a minimum Blended MLR of eighty-five (85) percent in the aggregate for the Contractor's Enrollee population.

4.5.5.2.3.4. Calculation of the Contractor's Blended MLR for the purposes of determining whether the Contractor has maintained such minimum shall occur before any reconciliation under the risk sharing arrangement set forth in **Section 4.5.3**.

4.5.5.3. Pursuant to 42 C.F.R. § 438.604(a)(3), and any additional EOHHS guidance, such report shall include all of the data on the basis of which EOHHS will determine the Contractor's compliance with the Medicaid MLR requirement set forth in 42 C.F.R. § 438.8. EOHHS will also use this report to inform the combined Medicare and Medicaid program level financial performance. Such MLR calculations described in **Sections 4.5.5.1. and 4.5.5.2**. above shall include at least the following, pursuant to 42 CFR 438.8(k):

4.5.5.3.1. Total incurred claims;

4.5.5.3.2. Expenditures on quality improvement activities;

4.5.5.3.3. Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1)-(5), (7), (8), and (b);

4.5.5.3.4. Non-claims costs; and

4.5.5.3.5. Premium Revenue;

4.5.5.3.5.1. For the Medicaid MLR under **Section 4.5.5.1** above, the Premium Revenue shall reflect Medicaid revenue. The Contractor shall include the amounts paid back to the Contractor under all quality withhold and quality incentive payments as part of the MLR denominator.

4.5.5.3.5.2. For the Blended Medicare-Medicaid MLR under **Section 4.5.5.2** above, the Premium Revenue shall be the sum of Medicaid revenue as described in **Section 4.5.5.3.5.1** above, and Medicare revenue.

4.5.5.3.6. Taxes, licensing, and regulatory fees;

4.5.5.3.7. Methodology(ies) for allocation of expenses;

4.5.5.3.8. Any credibility adjustment applied, consistent with EOHHS guidance;

4.5.5.3.9. Any remittance owed to EOHHS and/or CMS, if applicable;

4.5.5.3.10. The calculated MLR, which shall be the ratio of the numerator (as set forth in **Section 4.5.5.1.2.1.1**) to the denominator (as set forth in **Section 4.5.5.1.2.1.2**);

4.5.5.3.11. A comparison of the information reported in this **Section** with the audited financial report required under **Section 2.16**;

4.5.5.3.12. A description of the aggregation method used in calculating MLR;

4.5.5.3.13. The number of Member months;

4.5.5.3.14. An attestation that the calculation of the MLR is accurate and in accordance with 42 C.F.R. § 438.8 and relevant EOHHS guidance; and

4.5.5.3.15. Any other information required by EOHHS.

4.5.5.4. At its discretion, EOHHS may use the Contractor's submitted encounter data to verify the Contractor's reported Medicaid MLR and Blended MLR and may impose intermediate sanctions as described in **Section 5.4** in circumstances in which encounter data does not support the Contractor's reported Medicaid MLR and/or Blended MLR.

4.6. Payment in Full

4.6.1. The Contractor shall 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.

4.7. Performance Incentive Arrangements and Withholds

4.7.1. General

4.7.1.1. Each month EOHHS may withhold a percentage of the Contractor's Capitation Payment for Performance Incentives.

4.7.1.2. All Performance Incentive withholds shall meet the following requirements:

4.7.1.2.1. Performance Incentive withholds shall be for a fixed period of time, which shall be described in the specific Performance Incentive;

4.7.1.2.2. No Performance Incentive withhold shall be renewed automatically;

4.7.1.2.3. All Performance Incentive withholds shall be made available to both public and private Contractors under the same terms of performance;

4.7.1.2.4. No Performance Incentive withhold shall be conditioned on intergovernmental transfer agreements;

4.7.1.2.5. All Performance Incentives withholds shall be necessary for the specified activities, targets, and performance measures or quality-based outcomes that support program initiatives as specified by the state's quality strategy under 42 CFR 438.340; and

4.7.1.2.6. The Contractor's performance under any Performance Incentive withhold shall be measured during the Contract Year in which the Performance Incentive withhold is effective.

4.7.2. Quality Withhold Policy

4.7.2.1. EOHHS will withhold a percentage of the Capitation Rate. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.7.2.2. EOHHS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

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

4.7.2.4. Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology are available in **Appendix B** and **Appendix L**.

4.7.2.5. Withhold Measures in Contract Years 1 through 5

4.7.2.5.1. The quality withhold will be 3.25% in Contract Year 1. EOHHS may increase the quality withhold in Years 2, 3, 4, and 5, by no more than a 0.25% increase in each subsequent Year.

4.7.2.5.2. Payment will be based on performance on the quality withhold measures listed in **Figure 4.7-1**, below. The Contractor shall report these measures according to the prevailing technical specifications for the applicable measurement year.

4.7.2.5.3. If the Contractor is unable to meet minimum requirements sufficient to formally report at least three (3) of the quality withhold measures listed in **Figure 4.7-1** for a given year due to low enrollment or inability to meet other measurement criteria, EOHHS shall pay the Contractor the amount withheld for the quality withhold payment. The payment shall be contingent upon the Contractor completing and submitting the HEDIS IDSS file to EOHHS.

Figure 4.7-1: Quality Withhold Measures for Contract Years 1 through 5

Measure	Measure Steward/ Data Source	NQF #	State-Specified Withhold Measure
Controlling High Blood Pressure	NCQA	0018	X
Colorectal Cancer Screening	NCQA	0034	X
Follow-up After Hospitalization for Mental Illness	NCQA	0576	X
Medication Reconciliation Post-Discharge (Transitions of Care)	NCQA	0097	X
Member Experience (MA PDP CAHPS)	CMS	N/A	X
Long-Term Services and Supports Minimizing Facility Length of Stay	CMS	3457	X
Care for Older Adults: Functional Status Assessment (sub measures)	NCQA	0062	X
Pharmacotherapy Management of COPD Exacerbation (PCE)	NCQA	0549	X
Use of High-Risk Medications in Older Adults	NCQA	0022	X
Plan All-Cause Readmissions	NCQA	1768	X

4.7.3. Finder's Fee Performance Incentive

4.7.3.1. If, as further described in **Section 2.3.6**, EOHHS determines the Contractor meets the requirements to receive a finder's fee performance incentive, the amount of the incentive payment shall be equal to 50% of the Contractor's pro rata amount of the net state share of the total settlement or verdict amount, based on the Contractor's percentage of the single damages from covered conduct over the relevant time period as determined by EOHHS. The net state share is the gross amount of the verdict or settlement minus any amounts owed as a repayment of federal financial participation to the federal government or other restitution called for in the verdict or settlement.

4.7.4. CBHC Incentive Program

4.7.4.1. At a frequency specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of provider payments for the CBHC Incentive Program described in **Section 2.9.11** for the applicable time period.

4.7.4.2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in this section and in **Section 2.9.11**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

5 Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The Contractor shall 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 shall notify EOHHS in writing no later than sixty (60) days prior to any material change to the way services are rendered to Enrollees, including but not limited re-procurement or termination of a Material Subcontractor to implementation of new systems or large-scale system updates. The Contractor shall notify EOHHS and CMS in writing, of all other changes no later than five (5) business days prior to the effective date of such change. The Contractor shall notify EOHHS in writing no later than ninety (90) days prior to the effective date of any material administrative and operational change with respect to the Contractor, including but not limited to a change to the Contractor's corporate structure, ownership, or tax identification number.

5.1.2. Assignment or Transfer

5.1.2.1. The Contractor shall not assign or transfer any right or interest in this Contract to any successor entity or other entity, including any entity that results from a merger of the Contractor and another entity, without the prior written consent of EOHHS. The Contractor shall include in such request for approval a detailed plan for EOHHS to review. The purpose of the plan review is to ensure uninterrupted services to Enrollees, evaluate the new entity's ability to support the Provider Network, ensure that services to Enrollees are not diminished and that major components of the organization and EOHHS programs are not adversely affected by the assignment or transfer of this Contract.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, Material 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, EOHHS or the Commonwealth of Massachusetts, or CMS.

5.1.4. Subrogation

5.1.4.1. Subject to EOHHS and CMS lien and third-party recovery rights, the Contractor shall:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both

provided under this Contract up to the amount of the benefits provided hereunder; and

5.1.4.1.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or their insurer to the extent of the benefits provided hereunder.

5.1.5. Advance Directives

5.1.5.1. The Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives, and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information shall reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.1.6. Prohibited Affiliations and Exclusion of Entities

5.1.6.1. In accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting, provider, Material 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 from certain procurement and non-procurement activities, under federal or state law, regulation, executive order, or guidelines. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any such prohibited affiliations identified by the Contractor.

5.1.6.2. The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b).

5.1.7. Provider Incentive Plans

5.1.7.1. Incentive payment contracts between the Contractor and Network Providers shall:

5.1.7.1.1. Have a defined performance period that can be tied to the applicable MLR reporting periods;

5.1.7.1.2. Be signed and dated by all appropriate parties before the commencement of the applicable performance period;

5.1.7.1.3. Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that the Network Provider must meet to receive the incentive payment; and

5.1.7.1.4. Specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including a date of payment.

5.1.7.2. The Contractor shall:

5.1.7.2.1. As directed by EOHHS, maintain documentation to support the provider incentive payments;

5.1.7.2.2. Not use attestations as supporting documentation for data that factor into the MLR calculation; and

5.1.7.2.3. Make incentive payment contracts, and any documentation required in **Section 5.1.7.2.1**, available to EOHHS upon request.

5.1.7.3. Physician Incentive Plans

5.1.7.3.1. The Contractor may, in its discretion, operate a physician incentive plan only if:

5.1.7.3.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

5.1.7.3.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Enrollee; and

5.1.7.3.1.3. The applicable stop-loss protection, Enrollee survey, and disclosure requirements of 42 CFR Part 417 are met.

5.1.7.3.2. The Contractor shall comply, and assure its Material Subcontractors comply, with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210. The Contractor shall submit all information required to be disclosed to EOHHS in the manner and format specified by EOHHS.

5.1.7.3.3. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor's or its Material Subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210, 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, that it has made a good faith effort to comply with the cited requirements.

5.1.8. National Provider Identifier

5.1.8.1. The Contractor shall require each Provider 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 shall provide such unique identifier to EOHHS for each of its PCPs in the format and time frame established by EOHHS.

5.1.9. Provider-Enrollee Communications

5.1.9.1. In accordance with 42 USC 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient, for the following:

5.1.9.1.1. The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

5.1.9.1.2. Any information the Enrollee needs to decide among all relevant treatment options;

5.1.9.1.3. The risks, benefits, and consequences of treatment or non-treatment; and

5.1.9.1.4. The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

5.1.9.2. Notwithstanding the provisions of **Section 5.1.9** 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 shall furnish information about any service the Contractor does not cover due to moral or religious grounds as follows.

5.1.9.2.1. To EOHHS:

5.1.9.2.1.1. With its application for a Medicaid contract; and

5.1.9.2.1.2. At least sixty (60) days prior to adopting the policy during the term of the Contract.

5.1.9.2.2. To potential Enrollees, via enrollment/Marketing materials, at least thirty (30) days prior to adopting the policy during the term of the contract.

5.1.9.2.3. To Enrollees, at least thirty (30) days prior to adopting the policy during the term of the Contract and in the Member Handbook. The Contractor shall also describe in the Member Handbook that the Enrollee may access such services by contacting MassHealth directly and provide contact information.

5.1.9.3. The Contractor shall accept a reduction in the Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

5.1.10. No Enrollee Liability for Payment

5.1.10.1. The Contractor shall:

5.1.10.1.1. Ensure, in accordance with 42 USC §1396 u-2(b)(6) and 42 CFR 438.106, that an Enrollee will not be held liable:

5.1.10.1.1.1. For debts of the Contractor, in the event of the Contractor's insolvency;

5.1.10.1.1.2. For services provided under this Contract, except as otherwise provided in **Section 2.7.3**, to the Enrollee in the event that:

5.1.10.1.1.2.1. The Contractor fails to receive payment from EOHHS or CMS for such services; or

5.1.10.1.1.2.2. A Provider fails to receive payment from EOHHS, CMS, or the Contractor for such services.

5.1.10.1.2. Not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a debt that has not been paid.

5.1.10.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any charge permitted under **Section 5.1.10.2**.

5.1.10.1.4. Return to the Enrollee the amount of any liability inappropriately imposed on and paid by the Enrollee.

5.1.10.2. Copayments and Cost-sharing

5.1.10.2.1. As described in **Section 2.7.3**, the Contractor shall not charge Medicaid cost-sharing or Medicare Part C premiums to Enrollees, and shall cover Medicare Parts A or B cost-sharing.

5.1.10.2.2. The Contractor shall not charge an Enrollee for coinsurance, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as specifically authorized by EOHHS in writing.

5.1.10.2.3. The Contractor shall ensure Provider compliance with all Enrollee cost-sharing and payment restrictions.

5.1.10.2.4. The Contractor shall implement cost-sharing compliance processes as directed by EOHHS. The Contractor shall submit such process to EOHHS for EOHHS approval, modify any part of the process upon receiving feedback from EOHHS, and resubmit such updated proposed process for EOHHS approval.

5.1.10.2.4.1. Such processes shall minimally address situations in which an Enrollee is erroneously charged cost-sharing by a Provider and shall not require an Enrollee taking initial action (also referred to as Member overage).

5.1.10.2.4.2. The Contractor shall implement the final, EOHHS-approved process and report on overages as specified in **Appendix A**.

5.1.10.2.5. Consistent with the requirements of 42 CFR 422.100, the Contractor shall track the Medicare cost-sharing amounts charged for Enrollees toward the Medicare Maximum Out of Pocket (MOOP) limit and shall apply the data obtained through tracking amounts charged for Enrollees toward the MOOP limit to claims processing and encounter data for purposes of identifying actual Medicaid costs for Dual Eligible individuals.

5.1.11. Disclosure Requirements

5.1.11.1. 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.

5.1.11.2. The Contractor shall make the following federally required disclosures in accordance with 42. CFR § 455.100, et seq. and 42 U.S.C. § 1396b(m)(4)(A) in the form and format specified by EOHHS.

5.1.11.2.1. Ownership and Control

5.1.11.2.1.1. Upon any renewal or extension of this Contract and within thirty-five (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 Material Subcontractors. The Contractor shall complete the validation of federally required disclosure forms for their Material Subcontractors to ensure that the information is complete, and individuals are in good stead by conducting routine checks of federal databases.

5.1.11.2.2. Business Transactions

5.1.11.2.2.1. Within thirty-five (35) days of a written request by EOHHS, 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.

5.1.11.2.3. Criminal convictions

5.1.11.2.3.1. 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.

5.1.11.2.4. Other disclosures

5.1.11.2.4.1. The Contractor shall comply with all reporting and disclosure requirements of 41 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act; and

5.1.11.2.4.2. In accordance with Section 1903(m)(4)(B) of the Social Security Act, the Contractor shall make such reports regarding certain transactions with parties of interest available to Enrollees upon reasonable request.

5.1.11.2.5. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Sections 5.1.11.2.1-3** above, the Contractor shall fully and accurately complete the EOHHS

forms developed for such purpose as specified by EOHHS, including any EOHHS form for the disclosure and any EOHHS form required to post such disclosure on EOHHS's website in accordance with federal law, often referred to as the MassHealth Federally-Required Disclosures Form and Addendum, respectively.

5.1.11.2.6. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 5.1.11** or in response to the information contained in the Contractor's disclosures under this **Section 5.1.11**. 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.

5.1.12. Medicaid Drug Rebate

5.1.12.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.12.2. The Contractor shall submit to EOHHS, on a timely and periodic basis no less than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by the National Drug Code of each non Part D covered outpatient drug dispensed to Enrollees and other data as EOHHS determines necessary.

5.1.12.3. 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.

5.1.13. Termination Authority

5.1.13.1. The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

5.1.14. Additional Modifications to the Contract Scope

5.1.14.1. In its sole discretion, EOHHS may, upon written notice to the Contractor:

5.1.14.1.1. Modify Covered Services;

5.1.14.1.2. Modify Eligible populations;

5.1.14.1.3. Require the Contractor to enhance its policies and procedures for promoting information sharing, certified electronic health record (EHR) systems, and Mass HIway connections;

5.1.14.1.4. Modify access and availability requirements and standards;

5.1.14.1.5. Implement standardized provider credentialing policies and procedures;

5.1.14.1.6. Implement new Encounter Data reporting formats, including, but not limited to, HIPAA 837 standards or X12 837 Post-Adjudicated Claims Data Reporting (PACDR) standards for submission of professional, institution, and dental Encounters and NCPDP format for submission of pharmacy Encounters as well as 277CA for reporting errors, not including Provider or Enrollee supplemental files;

5.1.14.1.7. Modify the Withhold provisions; and

5.1.14.1.8. Modify the scope of this Contract to implement other initiatives in its discretion.

5.2. Privacy and Security of Personal Data and HIPAA Compliance

5.2.1. Covered Entities

5.2.1.1. EOHHS and the Contractor acknowledge that they are covered entities, as defined at 45 CFR 160.103.

5.2.2. Contractor's Compliance with HIPAA

5.2.2.1. The Contractor represents and warrants that:

5.2.2.1.1. It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;

5.2.2.1.2. It shall work cooperatively with EOHHS on all activities related to ongoing compliance with HIPAA requirements, as directed by EOHHS; and

5.2.2.1.3. It shall execute, at EOHHS's direction, a Trading Partner Agreement and any other agreements EOHHS determines are necessary to comply with HIPAA requirements.

5.2.3. Research Data

5.2.3.1. The Contractor shall seek and obtain prior written authorization from EOHHS for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.2.4. Statutory Requirements

5.2.4.1. 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 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93 579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.5. Personal Data

5.2.5.1. The Contractor shall inform each of its employees having any involvement with personal data or other confidential information of the laws and regulations relating to confidentiality.

5.2.6. Data Security

5.2.6.1. The Contractor shall take reasonable steps to ensure the security of personal data or other protected information under its control to ensure it is not compromised. The Contractor shall put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c). The Awardee shall meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. part 164, subpart C, the HIPAA Security Rule.

5.2.7. Return of Personal Data

5.2.7.1. The Contractor shall return 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 shall destroy such data or material.

5.2.8. Destruction of Personal Data

5.2.8.1. For any PHI received regarding an Eligible Beneficiary referred to Contractor by EOHHS who does not enroll in Contractor's plan, the Contractor shall destroy the PHI in accordance with standards set forth in National Institute of Science and Technology (NIST) Special Publication 800 88, Guidelines for Media Sanitizations, and all applicable State and federal Privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. Compliance with Laws

5.3.1.1.1. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Assisted Suicide Funding Restriction Act of 1997, Titles XIX and XXI of the Social Security Act and waivers thereof, Chapter 141 of the Acts of 2000 and applicable regulations, Chapter 58 of the Acts of 2006 and applicable regulations, 42 CFR Part 438, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations, and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, including but not limited to Section 1557 of such Act, to the extent such provisions apply and other laws regarding privacy and confidentiality, and as applicable, the Clean Air Act, Federal Water Pollution Control Act, and the Byrd Anti-Lobbying Amendment and, as applicable, the CMS Interoperability and Patient Access Final Rule (CMS 9115-F).

5.3.1.1.2. In accordance with 130 CMR 450.123(B), the Contractor shall review its administrative and other practices, including the

administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance and submit a certification to EOHHS in accordance with 130 CMR 450.123(B)(1)-(3) and any additional instructions provided by EOHHS.

5.3.1.1.3. The Contractor shall be liable for all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Loss of Licensure

5.3.3.1. If, at any time during the term of this Contract, the Contractor or any of its Providers or Material Subcontractors incurs loss of clinical licensure, accreditation or necessary state or federal approvals, the Contractor shall report such loss to CMS and EOHHS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.6**.

5.3.4. Indemnification

5.3.4.1. 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 negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, or any of its Material Subcontractors provided that:

5.3.4.1.1. The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim; and

5.3.4.1.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.5. Prohibition against Discrimination

5.3.5.1. In accordance with 42 USC § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting

within the scope of the Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of Providers in its network, it shall give the affected providers 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.

5.3.5.2. 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.

5.3.5.3. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.3(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against a Member eligible to enroll in the Contractor's MassHealth Plan on the basis of health status, need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

5.3.6. Anti-Boycott Covenant

5.3.6.1. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, shall 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 5.3.6**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

5.3.7. Information Sharing

5.3.7.1. 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 shall 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 be directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to

Enrollees who are children in the care or custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee's medical records and any Care Management documentation in a timely manner.

5.3.8. Other Contracts

5.3.8.1. Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder, provided, however, that the Contractor shall provide EOHHS with a complete list of such plans and services, upon request. EOHHS shall exercise discretion in disclosing information which the Contractor may consider proprietary, except as required by law. Nothing in this Contract shall be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.9. Title and Intellectual Property Rights

5.3.9.1. Definitions

5.3.9.1.1. The term "Property" as used herein includes the following forms of property: (1) confidential, proprietary, and trade secret information, (2) trademarks, trade names, discoveries, inventions processes, methods and improvements, whether or not patentable or subject to copyright protection and whether or not reduced to tangible form or reduced to practice, and (3) works of authorship, wherein such forms of property are required by the Contractor to develop, test, and install the any product to be developed that may consist of computer programs (in object and source code form), scripts, data, documentation, text, photographs, video, pictures, sound recordings, training materials, images, techniques, methods, program images, text visible on the Internet, illustrations, graphics, pages, storyboards, writings, drawings, sketches, models, samples, data, other technical or business information, reports, and other works of authorship fixed in any tangible medium.

5.3.9.1.2. The term "Deliverable" as used herein is defined as any work product that the Contractor delivers for the purposes of fulfilling its obligations under the Contract.

5.3.9.2. Contractor Property and License

5.3.9.2.1. The Contractor shall retain all right, title and interest in and to all Property developed by it, i) for clients other than the Commonwealth, and ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual

property rights created by the Contractor in connection with such work (hereinafter the “Contractor Property”). EOHHS acknowledges that its possession, installation or use of Contractor Property will not transfer to it any title to such property. “Contractor Property” also includes Contractor’s proprietary tools, methodologies and materials developed prior to the performance of Services and used by Contractor in the performance of its business and specifically set forth in this Contract and which do not contain, and are not derived from, EOHHS’s Confidential Information, EOHHS’s Property or the Commonwealth Data.

5.3.9.2.2. Except as expressly authorized herein, EOHHS will not copy, modify, distribute or transfer by any means, display, sublicense, rent, reverse engineer, decompile or disassemble Contractor Property

5.3.9.2.3. The Contractor 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, copy, sublicense to any EOHHS subcontractor for purposes of creating, implementing, maintaining or enhancing a Deliverable, and create derivative works based upon Contractor Property, in any media now known or hereafter known, to the extent the same are embodied in the Deliverables, or otherwise required to exploit the Deliverables. During the Contract Term and immediately upon any expiration or termination thereof for any reason, the Contractor shall provide to EOHHS the most current copies of any Contractor Property to which EOHHS has rights pursuant to the foregoing, including any related Documentation.

5.3.9.2.4. Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of Contractor Property under the license created herein, the Contractor shall have all the rights and incidents of ownership with respect to Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties. The Contractor shall not encumber or otherwise transfer any rights that would preclude a free and clear license grant to the Commonwealth.

5.3.9.3. Commonwealth Property

5.3.9.3.1. In conformance with the Commonwealth Terms and Conditions, all Deliverables created under this Contract whether made by the Contractor, Material Subcontractor or both are the property of EOHHS, except for the Contractor Property embodied in the Deliverable. The Contractor irrevocably and unconditionally sells, transfers and assigns to EOHHS or its designee(s), the entire right, title, and interest in and to all intellectual property rights that it may now or hereafter possess in

said Deliverables, except for the Contractor Property embodied in the Deliverables, and all derivative works thereof. This sale, transfer and assignment shall be effective immediately upon creation of each Deliverable and shall include all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor or Material Subcontractor in connection with such work (hereinafter the “Commonwealth Property”). “Commonwealth Property” shall also include the specifications, instructions, designs, information, and/or materials, proprietary tools and methodologies including, but not limited to software and hardware, owned, licensed or leased by EOHHS and which is provided by EOHHS to the Contractor or of which the Contractor otherwise becomes aware as well as EOHHS’s Confidential Information, the Commonwealth Data and EOHHS’s intellectual property and other information relating to its internal operations.

5.3.9.3.2. All material contained within a Deliverable and created under this Contract are works made for hire.

5.3.9.3.3. The Contractor agrees to execute all documents and take all actions that may be reasonably requested by EOHHS to evidence the transfer of ownership of or license to intellectual property rights described in this **Section 5.3** including providing any code used exclusively to develop such Deliverables for EOHHS and the documentation for such code. The Commonwealth retains all right, title, and interest in and to all derivative works of Commonwealth Property.

5.3.9.3.4. EOHHS hereby grants to the Contractor a nonexclusive, revocable license to use, copy, modify and prepare derivative works of Commonwealth Property only during the term and only for the purpose of performing services and developing Deliverables for the EOHHS under this Contract.

5.3.9.3.5. The Contractor agrees that it will not: (a) permit any third party to use Commonwealth Property, (b) sell, rent, license or otherwise use the Commonwealth Property for any purpose other than as expressly authorized under this Contract, or (c) allow or cause any information accessed or made available through use of the Commonwealth Property to be published, redistributed or retransmitted or used for any purpose other than as expressly authorized under this Contract. The Contractor agrees not to, modify the Commonwealth Property in any way, enhance or otherwise create derivative works based upon the Commonwealth Property or reverse engineer, decompile or otherwise attempt to secure the source code for all or any part of the Commonwealth Property, without EOHHS’s express prior consent. EOHHS reserves the right to modify or eliminate any portion of the Commonwealth Property in any way at any time. EOHHS may terminate use of the Commonwealth Property by the Contractor immediately and

without prior notice in the event of the failure of such person to comply with the security or confidentiality obligations hereunder. The Commonwealth Property is provided “AS IS” and EOHHS FOR ITSELF, ITS AGENCIES AND ANY RELEVANT AUTHORIZED USERS EXPRESSLY DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES CONCERNING THE COMMONWEATH PROPERTY, COMMONWEALTH DATA OR ANY THIRD PARTY CONTENT TO BE PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, OR STATUTORY, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF NONINFRINGEMENT, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR QUALITY OF SERVICES."

5.3.10. Counterparts

5.3.10.1. 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.

5.3.11. Entire Contract

5.3.11.1. 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 except as otherwise provided in **Section 5.3.15**. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein. This Contract, including the Commonwealth of Massachusetts Standard Contract Form and Commonwealth Terms and Conditions, shall supersede any conflicting verbal or written agreements, forms, or other documents relating to the performance of this Contract.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party’s obligations under this Contract.

5.3.13. Section Headings

5.3.13.1. The headings of the Sections of this Contract are for convenience only and will not affect the construction hereof.

5.3.14. Additional Administrative Procedures

5.3.14.1. 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 shall comply with all such program memoranda as may be issued from time to time.

5.3.15. Effect of Invalidity of Clauses

5.3.15.1. 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. Moreover, the Contractor shall comply with any such applicable state or federal law or regulation.

5.3.16. Insurance for Contractor's Employees

5.3.16.1. The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, shall obtain and maintain appropriate professional liability insurance coverage. The Contractor shall, at EOHHS's request, provide certification of professional liability insurance coverage.

5.3.16.2. The Contractor shall offer health insurance to its employees.

5.3.17. Waiver

5.3.17.1. EOHHS's exercise or non-exercise of any authority under this Contract, including, but not limited to, review and approval of materials submitted in relation to the Contract, shall not relieve the Contractor of any obligations set forth herein, nor be construed as a waiver of any of the Contractor's obligations or as acceptance by EOHHS of any unsatisfactory practices or breaches by the Contractor.

5.4. Intermediate Sanctions and Civil Monetary Penalties

5.4.1. General Requirements

5.4.1.1. In addition to termination under **Section 5.6**, EOHHS may impose any or all of the sanctions in **Section 5.4** upon any of the events below, provided, however, that EOHHS will only impose those sanctions it determines to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed if the Contractor:

5.4.1.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.4.1.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.4.1.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.4.1.1.4. Misrepresents or falsifies information provided to CMS, EOHHS, Enrollees, Members, contractors, or Providers;

5.4.1.1.5. Fails to comply with requirements regarding physician incentive plans (see **Section 5.1.7.3**);

5.4.1.1.6. Fails to comply with federal or State statutory, regulatory, bulletins or other sub-regulatory requirements related to this Contract;

5.4.1.1.7. Violates restrictions or other requirements regarding marketing;

5.4.1.1.8. Fails to comply with quality management requirements consistent with **Section 2.14**;

5.4.1.1.9. Fails to comply with any corrective action plan required by EOHHS;

5.4.1.1.10. Fails to comply with financial solvency requirements;

5.4.1.1.11. Fails to meet one or more of the standards for Encounter Data described in this Contract, including accuracy, completeness, timeliness, and other standards for Encounter Data described in **Section 2.15.2**;

5.4.1.1.12. Fails to comply with reporting requirements; or

5.4.1.1.13. Fails to comply with any other requirements of this Contract.

5.4.1.2. Such sanctions may include, but are not limited to:

5.4.1.2.1. Civil money penalties in accordance with 42 CFR 438.704;

5.4.1.2.2. Financial measures or penalties EOHHS determines are appropriate to address the violation;

5.4.1.2.3. Intermediate sanctions consistent with 42 C.F.R. § 438 Subpart I;

5.4.1.2.4. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396 u 2(e)(2)(B) and 42 C.F.R. § 438.706;

5.4.1.2.5. Notifying the affected Enrollees of their right to disenroll;

5.4.1.2.6. Suspension of enrollment;

5.4.1.2.7. Suspension of payment to the Contractor for Enrollees enrolled 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;

5.4.1.2.8. Disenrollment of Enrollees,

5.4.1.2.9. Suspension of marketing;

5.4.1.2.10. Limitation of the Contractor's coverage area;

5.4.1.2.11. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance, and

5.4.1.2.12. Such other measures as EOHHS determines appropriate to address the violation.

5.4.1.3. Before imposing any intermediate sanctions, EOHHS shall provide the Contractor timely written notice that explains the basis and nature of the sanction.

5.4.1.4. If EOHHS has identified a deficiency in the performance of a Material Subcontractor and the Contractor has not successfully implemented a corrective action plan in accordance with **Section 5.4.3**, EOHHS may:

5.4.1.4.1. Require the Contractor to subcontract with a different Material Subcontractor deemed satisfactory by EOHHS; or

5.4.1.4.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.4.2. Encounter Data Capitation Payment Deduction

5.4.2.1. For each month where the Contractor has not met data submission standards for Encounter Data as described in **Section 2.15.2**, **Appendix A**, and elsewhere in this Contract, EOHHS may apply Capitation Payment deduction as follows:

5.4.2.1.1. EOHHS may deduct two (2%) percent from the Contractor's Capitation Payment for each month;

5.4.2.1.2. Once the Contractor has corrected the data submission and EOHHS is able to validate its accuracy EOHHS shall pay the Contractor the amount of the deduction applied; and

5.4.2.1.3. Nothing in this section shall prohibit EOHHS from imposing additional sanctions for the failure to accurately report Encounter Data.

5.4.3. Corrective Action Plan

5.4.3.1. If, at any time, EOHHS reasonably determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. EOHHS may accept, reject, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall incorporate all modifications and shall promptly and diligently implement the corrective action plan and demonstrate to EOHHS that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan promptly and diligently may subject the Contractor to termination of the Contract by EOHHS or other intermediate sanctions as described in **Section 5.4**.

5.4.3.2. EOHHS may also initiate a corrective action plan for the Contractor to implement. The Contractor shall promptly and diligently implement any EOHHS-initiated corrective action plan. Failure to implement the corrective action plan promptly and diligently may subject the Contractor to termination of the Contract by EOHHS or other Intermediate Sanctions as described in this **Section 5.4**.

5.5. Record Retention, Inspection, and Audit

5.5.1. The Contractor shall cause the administrative and medical records maintained by the Contractor, its Material Subcontractors, and Network Providers, as required by EOHHS and other regulatory agencies, to be made available to EOHHS and its agents, designees or contractors, any other authorized representatives of the Commonwealth of Massachusetts or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial and/or medical audits, programmatic review, inspections, and examinations, provided that such activities shall be conducted during the normal business hours of the Contractor. Such records shall be maintained and available to EOHHS for seven (7) years. Such administrative and medical records shall include but not be limited to Care Management documentation, financial statements, Provider Contracts, contracts with Material Subcontractors, including financial provisions of such Provider Contracts and Material Subcontractor contracts. The Contractor further agrees that the

Secretary of the U.S. Department of Health and Human Services or his designee, the Governor or his designee, and the State Auditor or his designee may inspect and audit any financial records of the Contractor or its Material Subcontractors.

5.5.2. Notwithstanding the generality of the foregoing, pursuant to 42 CFR 438.3(h), EOHHS, other representatives from the Commonwealth of Massachusetts, CMS, the Office of the Inspector General, the Comptroller General, and their designees, may, at any time, inspect and audit any records or documents of the Contractor or its Material Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this Section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later. The Contractor shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

5.5.3. In cases where such an audit or review results in EOHHS believing an overpayment has been made, EOHHS may seek to pursue recovery of overpayments. EOHHS will notify the Contractor in writing of the facts upon which it bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than EOHHS), EOHHS will so inform the Contractor and, in such cases, the Contractor may contest only the factual assertion that the federal or state agency made such a determination. The Contractor may not contest in any proceeding before or against EOHHS the amount or basis for such determination.

5.6. Termination of Contract

5.6.1. Termination without Prior Notice

5.6.1.1. In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, EOHHS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. EOHHS may terminate the Contract in accordance with regulations that are current at the time of the termination.

5.6.1.2. Without limiting the above, if EOHHS determines that 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 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. Such action may precede beneficiary enrollment into any Contractor and shall be taken upon a finding by EOHHS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of covered services to eligible Beneficiaries.

5.6.1.3. United States law will apply to resolve any claim of breach of this Contract.

5.6.2. Termination with Prior Notice

5.6.2.1. EOHHS may terminate this Contract without cause upon no less than ninety (90) days prior written notice to the Contractor specifying the termination date unless applicable law requires otherwise. If the termination is pursuant to EOHHS's authority under 42 CFR 438.708, such notice shall include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1).

5.6.2.2. The Contractor may terminate this Contract without cause upon no less than one hundred and eighty (180) days prior written notice to EOHHS specifying the termination date unless applicable law requires otherwise.

5.6.2.3. In the event that this Contract is terminated with prior notice per this **Section 5.6.2**, the Contractor shall report Encounter Data and performance measurement results through the effective termination date of the Contract, including but not limited to HEDIS, HOS, and CAHPS, as outlined in **Section 2.15** unless otherwise permitted by EOHHS.

5.6.3. Termination for Cause

5.6.3.1. Either party may terminate this Agreement upon ninety (90) days' prior written notice due to a material breach of a provision of this Contract unless EOHHS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby EOHHS may expedite the termination.

5.6.3.2. Pretermination Procedures. Before terminating a contract under 42 CFR §438.708, such written notice provided by EOHHS shall include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1). Such written notice shall notify the Contractor of its Appeal rights as provided in 42 CFR §438.710.

5.6.4. Termination due to a Change in Law

5.6.4.1. In addition, EOHHS may terminate this agreement upon thirty (30) days' notice due to a material change in law, or with less or no notice if required by law.

5.6.5. Continued Obligations of the Parties

5.6.5.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan, provided, however, that EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.6.5.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.6.5.2.1. If EOHHS elects to terminate 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 care.

5.6.5.2.2. If the Contractor elects to terminate or not renew the Contract, the Contractor shall be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;

5.6.5.2.2.1. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.6.5.2.2.2. The Contractor shall 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 shall be paid to the Contractor accordingly.

5.6.5.2.3. If the Contractor has Continued Obligations as described in this section, the Contractor shall accept the Risk-Adjusted Capitation Rate as established by EOHHS for the Contract Year during which the Continued Obligations period is occurring, with a 1.5% reduction, subject to actuarial soundness as appropriate, as payment in full for Covered Services and all other services required under this Contract until all Enrollees have been disenrolled from the Contractor's Plan.

5.6.5.2.4. EOHHS shall calculate Gain and Loss as described in **Appendix E**, if any, from the end of the Contract Year in which the termination is

effective through the completion of all disenrollment activities. The Contractor shall pay EOHHS the MassHealth Share of any Gain. EOHHS shall not be obligated to pay the Contractor the MassHealth Share of any Loss.

5.6.5.2.5. The Contractor shall, to facilitate the transition of Enrollees to another SCO Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees with active prior authorizations, and Enrollees' active drug prescriptions.

5.7. Contract Term

5.7.1. This Contract shall be in effect as of the Contract Effective Date and end on December 31, 2030, subject to (1) the Contractor's acceptance of Capitation Rates as determined by EOHHS under this Contract, (2) the Contractor's satisfactory performance, as determined by EOHHS, of all duties and obligations under this Contract, and (3) the provisions of **Section 5.6** provided, however that EOHHS may extend the Contract in any increments up to December 31, 2035, at the sole discretion of EOHHS, upon terms agreed upon by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of the Contract is subject to mutual agreement on terms by both parties, further legislative appropriations, continued legislative authorization, and EOHHS's determination of satisfactory performance.

5.8. Amendments

5.8.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto. Further, the Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with all applicable state and federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Amendments of 1997 (BBA) and any regulations promulgated thereunder, the Deficit Reduction Act, and Health Care Reform, as well as any regulations, policy guidance, and policies and procedures related to any such applicable state and federal laws. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

5.8.2. EOHHS and Contractor mutually acknowledge that unforeseen policy, operational, methodological, or other issues may arise throughout the course of

this Contract. Accordingly, EOHHS and Contractor agree to work together in good faith to address any such circumstances and resolve them, and if necessary, will enter into amendments to this Contract on mutually agreeable terms.

5.9. Order of Precedence

5.9.1. The following documents are incorporated into and made a part of this Contract, including all appendices:

5.9.1.1. This Contract, including any Appendices and amendments hereto;

5.9.1.2. The Procurement for One Care and Senior Care Options (SCO) Plans RFR #23EHSKAONECARESCOPROCURE;

5.9.1.3. The Contractor's response to the Procurement for One Care and Senior Care Options (SCO) Plans RFR #23EHSKAONECARESCOPROCURE; and

5.9.1.4. Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.

5.9.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.9.2.1. This Contract, including all appendices;

5.9.2.2. The Procurement for One Care and Senior Care Options (SCO) Plans RFR #23EHSKAONECARESCOPROCURE;

5.9.2.3. The Contractor's response to the Procurement for One Care and Senior Care Options (SCO) Plans RFR #23EHSKAONECARESCOPROCURE; and

5.9.2.4. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.

5.10. Written Notices

5.10.1. 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:

5.10.1.1. To EOHHS:

Assistant Secretary for MassHealth
Executive Office of Health and Human Services

One Ashburton Place, 11th Floor
Boston, MA 02108

With Copies to:

General Counsel
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Chief, Long Term Services and Supports
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Director, MassHealth Integrated Care Program
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor Boston, MA 02108

5.10.1.2. To the Contractor:

5.10.1.2.1. Notice to the Contractor shall be provided to the individual identified in **Appendix O**.

APPENDIX A
SCO PROGRAMMATIC REPORTING REQUIREMENTS

This Appendix summarizes the reporting requirements described in the Contract. EOHHS may update these requirements from time to time, including through guidance or MCE Bulletins. The Contractor may include a narrative summary for reports/submissions and may include graphs that explain and highlight key trends. For any report that indicates that the Contractor is not meeting the target, the Contractor shall submit a detailed narrative that includes the results, an explanation as to why the Contractor did not meet the target, and the steps the Contractor is taking to improve performance going forward.

The Contractor shall provide all Reports in the form and format required by EOHHS and shall participate with EOHHS in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate.

All exhibits referenced herein pertain to **Appendix A**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report below. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time. EOHHS shall notify the Contractor of any updates to the exhibits.

Reporting Deliverable Schedule

1. **Same Day Notification (Immediate Notice Upon Discovery):** Deliverables due the same day as discovery. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.

2. **Weekly Deliverables:** Deliverables due by close of business/COB on Fridays.
3. **No later than 30 days prior to execution:** Deliverables due thirty calendar days prior to implementation for review and approval by EOHHS.

4. **Monthly Deliverables:** Deliverables due on a monthly basis, by the last business day of the month, following the month included in the data, unless otherwise specified by EOHHS.

5. **Quarterly Deliverables:** Deliverables due on a contract year (CY) quarterly basis, by the last business day of the month following the end of each quarter, unless otherwise specified.

   CY Quarter 1: January 1 – March 31

   CY Quarter 2: April 1 - June 30

   CY Quarter 3: July 1 – September 30

   CY Quarter 4: October 1 – December 31

6. **Semi-Annual Deliverables:** Deliverables due by the last business day of the month following the end of the reporting period, unless otherwise specified. The semi-annual reporting periods are as follows:

   January 1 – June 30

   July 1 – December 31

7. **Annual Deliverables**: Deliverables due by April 30 for the prior Contract Year (January 1 - December 31), unless otherwise specified by EOHHS.

8. **Ad-Hoc Deliverables**: Deliverables are due whenever the Contractor has relevant changes or information to report, or upon EOHHS request.

A. Report and Compliance Certification Checklist: Exhibit C-2

Annually - The Contractor shall list, *check off,* sign and submit a Certification of Data Accuracy for all Contract Management, Program Integrity, Organizational, Financial, Operations and Quality reports/submissions, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of the Contractor's knowledge, information and belief, after reasonable inquiry. For each report in the sections below, if an attestation is required with the submission, that

information will be included within the reporting template.

B. Contract Management Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM -1	Access and Availability Summary:	
CM-1-A	Geographic Access Report	Annually
CM-1-B	Ratio Reports: PCP to Enrollee	Annually
CM-1-C	Ratio Reports: Specialist to Enrollee	Annually
CM-1-D	Summary of Significant Changes in Provider Network	Annually
CM-1-E	Summary of Use of Out-of- Network Providers	Annually
CM -2	Assessment Completion Report	Monthly
CM -3	CMT Tracker	Rolling 6 Week
CM -4	Care Plan Completion Report	Monthly
CM -5	Care Coordinator Staffing Report	Monthly
CM -6	Claims Processing Report Regarding Timely Payments	Monthly
CM -7	Corrective Action Plan	Ad-Hoc
CM -8	Marketing Plan and Materials	Ad-Hoc

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM -9	Notification of Critical or Adverse Incidents	Ad-Hoc Notification: Within 3 Business Days
CM -10	Notification of Significant Changes in Provider Network	Ad-Hoc Notification: Same Day
CM -11	Submission of Member Outreach and Education Schedule	Quarterly
CM-12	Accessibility and Accommodations Compliance	Annually

C. Program Integrity Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
PI-1	Anti-Fraud, Waste and Abuse Plan and Compliance Plan	Annually
PI-2	Executive Order 504 Contractor Certification Form	At Contract Execution
PI-3	Notification of For-Cause Provider Suspensions and Terminations	Ad-Hoc
PI-4	Notification of Fraud and Abuse	Ad-Hoc
PI-5	Notification of PCP Suspensions and Terminations	Ad-Hoc
PI-6	Notification of Provider Exclusion	Ad-Hoc
PI-7	Notification of Provider Failure to Credential or Re-Credential	Ad-Hoc
PI-8	Notification of Provider Self-Reported Disclosures	Ad-Hoc
PI-9	Program Integrity Compliance Plan	Annually
PI-10	Response to Overpayments Identified by EOHHS	Ad-Hoc
PI-11	Summary of Fraud and Abuse	Quarterly
PI-12	Summary of Provider Overpayments	Semi-Annually

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
PI-13	Material Subcontractor Corrective Action Report	Ad-Hoc
PI-14	Monthly Identified and Recovered Overpayment Report	Monthly

D. Organizational and Process Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
OP-1	Board of Directors List	As of contract effective date
OP-2	Changes to Provider Credentialing Policies and Procedures	Annually
OP-3	Executive Order 504 Contractor Certification Form	At Contract Execution
OP-4	List of Key Personnel	Within 5 days of contract execution
OP-5	Notification of Change in Board of Directors	Ad-Hoc
OP-6	Notification of Required Self-Disclosure	Ad-Hoc Notification: Same Day
OP-7	Organizational Chart	Annually
OP-8	Checklist of Businesses Certified under 425 CMR 2.00	Annually
OP-9	Significant Organizational Changes, New Material Subcontractors (**Appendix K**), or Potential Business Ventures	Ad-Hoc
OP-10	Staff Retention and Employee Turnover	Ad-Hoc
OP-11	Updated Plan Provider Directory	Annually

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
OP-12	Updated Provider Manual	Annually

E. Financial Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
FR-01	Alternative Payment Models (APM) Report	Ad-Hoc
FR-02	Audited Financial Statements	Annually
FR-03	Certification of Sound Financial Condition	Annually
FR-04-A	Cost Avoidance and Recovery Identification	Semi-Annually
FR-04-B	Cost Avoidance and Recovery Identification: Accident and Trauma	Semi-Annually
FR-05	DOI Financial Reports	Quarterly
FR-06	Provider Risk Arrangements	Ad-Hoc
FR-07	Report on Any Default of the Contractor's Obligations OR Financial Obligation to a Third Party.	Ad-Hoc
FR-08	Service Organization Controls Type 1 (SOC1) report	Annually
FR-09	Working Capital Requirement Notification	Ad-Hoc
FR-10	Attestation Report from Independent Auditors on Effectiveness of Internal Controls	Annually

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
FR-11	Notification of Potential Insolvency	Ad-Hoc Notification: Same Day
FR-12	Notification to EHS Regarding Negative Change in Financial Status	Ad-Hoc Notification: Same Day
FR-13	Outstanding Litigation Summary	Annually
FR-14	Encounter Data Submission (Appendix H)	Monthly
FR-15	Quarterly Financial Report	Quarterly and Annually (3, 6,12, and 15-month refresh)

F. Quality Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
QR-01	Quality Improvement Goals (QM/QI work plan)	Annual
QR-02	CAHPS Report (Submission of full CAHPS Report)	Annual
QR-03	External Research Project Notification	Ad-Hoc
QR-04	External Audit/Accreditation	Ad-Hoc
QR-05	HEDIS IDSS Report	Annual
QR-06	Performance Improvement Projects	Bi-Annual
QR-07	Validation of Performance Measures	Ad-Hoc
QR-08	Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)	Notification: Within 30 calendar days of occurrence
QR-09	Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)	Annual
QR-10	Five-year Health Equity Strategic Plan Five-year Health Equity Plan	Annual

G. Operations Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
OP-01	Continuity of Operations Plan	Ad-Hoc
OP-02	Address Change File	Bi-Weekly
OP-03	Daily Inbound Demographic Change File	Daily
OP-04	Enrollment and Payment Discrepancy Report	Weekly
OP-05	Internal Management Report	Ad-Hoc
OP-06	Excluded Provider Monitoring Report	Monthly
OP-07	HIPAA 834 History Request File	Ad-Hoc
OP-08	Members boarding in Emergency Department or on Administratively Necessary Days (AND) Status	Daily

H. FIDE SNP Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
FS-01	Medicare Advantage D-SNP Bid Filing	Annual
FS-02	CAHPS and HEDIS Data and Reports	Annual
FS-03	Applying for Frailty Adjuster; receipt of Frailty Adjuster	Annual
FS-04	Medicare Risk Score data (Aggregate, by Rating Category, and at Enrollee level)	Monthly
FS-05	Supplemental Benefits Proposed and/or Approval Status (projections of cost and utilization)	Annual
FS-06	Details on actual utilization for Supplemental Benefits	Monthly
FS-07	Star Rating Rebate % and PMPM	Annual
FS-08	Medicare Audit processes, findings, and reports	Ad-Hoc
FS-09	Medicare compliance and penalty information	Ad-Hoc
FS-10	Participation in any Medicare VBP or APM initiatives, such as VBID	Ad-Hoc
FS-11	Model of Care Submission, Scoring, and NCQA Feedback	Annual
FS-12	Medicare Plan Benefit Package Submission	Annual

I. Pharmacy Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
PH-01	BIN/PCN/Group Number Report (Note: Due at least 30-days before new BIN/PCN/Group Number is effective)	Ad Hoc

J. Frail Elder Waiver Quality Reports

SCO Contract Exhibit Number	Name of Report	Deliverable Frequency
FEW-01	FEW Provider Workbook	Annual
FEW-02	FEW Service Plan Workbook	Annual
FEW-03	FEW Care Management Survey	Annual

APPENDIX B
SCO PERFORMANCE IMPROVEMENT GOALS

This appendix describes the requirements for the Quality Improvement Goals, Performance Improvement Projects, and Performance Measures as specified in **Section 2.14** of the Contract.

Performance Improvement Cycle

The Performance Improvement measurement cycle typically includes a planning/baseline period and up to 2 remeasurement cycles to allow for tracking of improvement gains. For each Performance Improvement cycle, EOHHS will establish a series of Performance Improvement Project domains as well as approve and/or designate measurement and quality improvement activities for each of those domains. The following paragraphs outline the CY26 PIP Cycle.

The SCO Plans are expected to conduct and report on a minimum of 2 Performance Improvement Projects (PIPs). The PIPs must be conducted in accordance with the PIP domains as specified in this Appendix or otherwise be approved by EOHHS. Additionally, all PIPs must be aligned with the performance measures outlined in **Exhibit 1** of this Appendix, unless otherwise specified or approved by EOHHS. EOHHS will provide standardized forms for all required reporting activities, including Quality Improvement Plans, PIP Progress Reports, and PIP Annual Reports. EOHHS reserves the right to modify annual PIP deliverables as necessary.

A. QI IMPLEMENATION DETAILS

The following section provides detailed information about the PIP implementation periods, and their associated activities.

Table 1: PIP Implementation Periods		
Timeframe	***Activities***	***Deliverable***
Contract Year 1	Project planning and baselining for a minimum of two PIPs	Project Proposal and/or Baseline Report for each PIP
Contract Year 2	Implementation of a minimum of two PIPs	Remeasurement Reports for each implemented PIP
Contract Year 3	Continuation of a minimum of two PIPs	Remeasurement/Closeout Reports for each implemented PIP

B. SCO PIP DOMAIN AREAS

SCO Plans are required to submit at least two distinct PIPs annually. PIP topics shall be consistent with QI domain areas described in Table 2. In addition to addressing each PIP domain, PIPs will also include a sub-focus on health equity.

Table 2: PIP Domain Areas – Reserved for Updates	
Domain 1:	
Project Focus:	
Domain 2:	
Project Focus:	

C. DOMAIN MEASURES AND INTERVENTIONS

SCO plans shall identify specific measures and interventions within their PIPs that are reflective of the quality performance and monitoring measures identified in **Exhibit** 1 of this Appendix.

D. SCO REPORTS, SUBMISSIONS, AND TEMPLATES

SCO plans will submit Performance Improvement Reports using the PIP Submission Templates developed and distributed by EOHHS or its designee. PIP Reporting submissions shall include quantitative and qualitative data as well as specific progress made on each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, SCO Plans shall refer to guidance to be distributed by MassHealth or its designee.

- Reporting on the interventions should at a minimum include the following items (to be described with greater specificity in the forthcoming Submission Guide Document):
- Rationale for selecting proposed/implemented interventions
- Description of current interventions
- Analysis of short-term indicators, HEDIS rates as applicable, data collection procedures and methodology, and interpretation of results
- Assessment of intervention successes and challenges, and potential intervention modifications for future implementation periods.

Evaluation of PIP Reports: EOHHS or its designee will review PIP Reports using a standardized Evaluation Template. The scoring elements in the Evaluation Template will correspond directly with the elements documented on the reporting templates. Feedback will be provided to the SCO plans for each implementation period and deliverables.

Cultural Competency

Participating SCO plans shall design and implement all PIP activities and interventions in a culturally competent manner.

Performance Measures

EOHHS has defined performance measures pursuant to **Section 2.14.3.1** of the Contract and reserves the right to modify the list of performance measures as deemed necessary and determined by EOHHS. EOHHS will calculate select measures on behalf of the SCO plans as indicated in **Exhibit 1**. SCO-calculated measures shall be submitted annually to EOHHS. The Contractor shall report measures separately for Dual Eligible and Medicaid only eligible Enrollees. In accordance with the Medicaid Managed Care Rule, the performance measures may be used by EOHHS to publicly report SCO performance. EOHHS reserves the right to withhold reporting of a measure(s) as determined by EOHHS.

EXHIBIT 1 – SCO Quality Measures (Prospective Measures, 2026-2030)

Measure Name	Measure Description	Data Source	Measure Steward	NQF
1. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	Claims	NCQA	1879
2. Advance Care Planning (ADP)	The percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.	Claim	NCQA	0326
3. Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	Claims	NCQA	N/A
4. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	The percentage of episodes for members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. A higher rate indicates appropriate treatment for bronchitis/bronchiolitis (i.e., the percentage of episodes that were not prescribed an antibiotic).	Claims	NCQA	0058
5. Breast Cancer Screening (BCS-E)	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	ECDS	NCQA	2372

Measure Name	Measure Description	Data Source	Measure Steward	NQF
6. Care for Older Adults (COA) • Medication Review • Functional Status Assessment**Error! Bookmark not defined.** • Pain Assessment	The percentage of adults 66 years of age and older who had each of the following during the measurement year: • Medication Review. • Functional Status Assessment. • Pain Assessment	Hybrid	NCQA	0553
7. Controlling High Blood Pressure* (CBP)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	Hybrid	NCQA	0018
8. Colorectal Cancer Screening**Error! Bookmark not defined.** (COL)	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Hybrid	NCQA	0034
9. Diabetes Care: Blood Sugar Controlled (HBD)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • HbA1c poor control (>9.0%).	Hybrid	NCQA	0575
10. Diagnosed Mental Health Disorders (DMH)	The percentage of members who were diagnosed with a mental health disorder during the measurement year.	Claims	NCQA	N/A
11. Diagnosed Substance Use Disorders (DSU)	The percentage of members 13 years of age and older who were diagnosed with a	Claims	NCQA	N/A

*Quality Withhold Measure

Measure Name	Measure Description	Data Source	Measure Steward	NQF
	substance use disorder during the measurement year. Four rates are reported: • The percentage of members diagnosed with an alcohol disorder. • The percentage of members diagnosed with an opioid disorder. • The percentage of members diagnosed with a disorder for other or unspecified drugs. • The percentage of members diagnosed with any substance use disorder.			
12. Follow-Up After Emergency Department Visit for Substance Use (FUA)	The percentage of emergency department (ED) visits among members with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Claims	NCQA	2605
13. Follow-Up After Emergency Department Visit for Mental Illness (FUM)	The percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:	Claims	NCQA	N/A

Measure Name	Measure Description	Data Source	Measure Steward	NQF
	• The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).			
14. Follow-up After Hospitalization for Mental Illness (FUH)*	Percentage of emergency department (ED) visits for adults 18 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.	Claims	NCQA	0576
15. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 18 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: • The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. • The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.	Claims	NCQA	

* Quality Withhold Measure

Measure Name	Measure Description	Data Source	Measure Steward	NQF
16. Influenza Vaccination (FVO)	The percentage of adults in commercial and Medicaid plans receiving an influenza vaccination between July 1 of the measurement year and the date when the commercial CAHPS survey was completed.	Survey	NCQA	0041
17. Member Experience – (MA PDP CAHPS)**Error! Bookmark not defined.**	Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys	Survey	CMS	N/A
18. EOHHS Long-Term Services and Supports Minimizing Facility Length of Stay*	The proportion of admissions to a facility among Medicaid MLTSS participants age 18 and older that result in successful discharge to the community (community residence for 60 or more days within 100 days of admission	Claims	CMS	3457
19. Initiation and Engagement of SUD treatment (IET) – Initiation Total and Engagement Total	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	Claims	NCQA	0004

Measure Name	Measure Description	Data Source	Measure Steward	NQF
20. Long-Term Services and Supports Comprehensive Care Plan and Update (CPU)	The percentage of long-term services and supports (LTSS) organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes core elements. The following rates are reported: • Care Plan With Core Elements Documented. Members who had a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members). • Care Plan With Supplemental Elements Documented. Members who had a comprehensive LTSS care plan with 9 core elements and at least 4 supplemental elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members).	Case Record Review	NCQA	N/A
21. Osteoporosis Management in Women Who Had a Fracture	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.	Claims	NCQA	0053

Measure Name	Measure Description	Data Source	Measure Steward	NQF
22. Persistence of Beta-Blocker Treatment after Heart Attack (PBH)	The percentage of adults 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.	Claims	HEDIS	0071
23. Pharmacotherapy Management of COPD Exacerbation (PCE)*	Percentage of adults 40 years of age and older who had appropriate medication therapy to manage a chronic obstructive pulmonary disease (COPD) exacerbation.	Claims	HEDIS	0549
24. Plan All-Cause Readmission (PCR)*	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	Claims	NCQA	1768
25. Potentially Harmful Drug-Disease Interaction in Older Adults (DDE)	Percentage of adults 65 years of age and older who have a specific disease or condition (chronic kidney disease, dementia, history of falls) and were dispensed a prescription for a medication that could exacerbate it. • The percentage of older adults with a history of falls who had a dispensed prescription for antiepileptics, antipsychotics,	Claims	NCQA	N/A

* Quality Withhold Measure

Measure Name	Measure Description	Data Source	Measure Steward	NQF
	benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs). • The percentage of older adults with diagnosed dementia who had a dispensed prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants or anticholinergic agents. • The percentage of older adults with chronic kidney disease who had a prescription for Cox-2 selective NSAIDs or non-aspirin NSAIDs.			
26. Transitions of Care (TRC) • Notification of Inpatient Admission • Receipt of Discharge Information. • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge*	The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported: • Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). • Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). • Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the	Hybrid	NCQA	N/A

Measure Name	Measure Description	Data Source	Measure Steward	NQF
	home, telehealth) provided within 30 days after discharge. • Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).			
27. Use of High-Risk Medication in Older Adults (DAE)†	Percentage of adults 67 years of age and older who had at least two dispensing events for the same high-risk medication. Two rates and a total rate are reported: • The percentage of older adults who had at least two dispensing events for high-risk medications from the same drug class where any use is inappropriate. • The percentage of older adults who had at least two dispensing events for high-risk medications to avoid, from the same drug class where use is potentially inappropriate except for specific conditions.	Claims	NCQA	0022
28. Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Percentage of adults 40 years of age and older who have a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD, who received spirometry testing to confirm the diagnosis.	Claims	NCQA	0577

* Quality Withhold Measure
† Quality Withhold Measure

APPENDIX C
SCO COVERED SERVICES DEFINITIONS

EXHIBIT 1: General Services

The Covered Services described in this Appendix represent minimum coverage scope for Enrollees under the MassHealth benefit for Medicaid coverage, and shall be provided in addition to coverage and scope available through Medicare Part A, Part B, and Part D.

Acupuncture Treatment - The insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, for pain relief or anesthesia. This service is distinct from Acupuncture services that are provided as a treatment for Substance Use Disorder, as described in **Appendix C, Exhibit 2**.

Adult Day Health - Community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, nutrition at a site outside the home, and transportation to a site outside the home. One-time payments for Adult Day Health Admission Services (S5105) and Re-engagement Services (S5105 KZ) pursuant to 101 CMR 310.00 are excluded from the Contractor's coverage of Adult Day Health; claims for such services shall be paid directly by MassHealth.

Adult Foster Care - Daily assistance in personal care, managing medication, meals, snacks, homemaking, laundry, and medical transportation.

Ambulatory Surgery/Outpatient Hospital Care – All outpatient surgical services and related diagnostic medical and services; dental services and oral surgery, as indicated under Dental Services in this **Appendix C, Exhibit 1**.

Audiologist – Audiologist exams and evaluations. See related hearing aid services.

Behavioral Health Inpatient Services - (See coverage details in Behavioral Health Services, **Appendix C, Exhibit 2**.)

Behavioral Health Outpatient Services – (See coverage details in Behavioral Health Services, **Appendix C, Exhibit 2**.)

Chiropractic Services – Chiropractic manipulative treatment, office visits, and radiology services.

Community Health Center Services - Provided by a freestanding institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111 s. 51 that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. A Community Health Center must be a nonprofit organization and must be open for the delivery of

medical services to the public on a regular schedule for a minimum of 20 hours per week. A Community Health Center must provide internal medicine, pediatric, and obstetrics/gynecology services, unless approved otherwise by MassHealth, as well as health education, medical social services and nutrition services. A Community Health Center must provide other medical services on site or, alternatively, through a referral network.

Continuous Skilled Nursing – A nursing visit of more than two continuous hours of nursing services for individuals living in the community. This service can be provided by a home health agency or an Independent Nurse (previously private duty nursing).

Day Habilitation - A structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for individuals with developmental disabilities who need active treatment. One-time payments for Day Habilitation Admission Services (S5105) and Re-engagement Services (S5105 KZ) pursuant to 101 CMR 348.00 are excluded from the Contractor's coverage of Day Habilitation; claims for such services shall be paid directly by MassHealth.

Dental Services –Restorative, and emergency oral health services; preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health; full and partial dentures, and repairs to said dentures; oral surgery which is Medically Necessary to treat a medical condition performed in any place of service, including but not limited to an outpatient setting, as described in Ambulatory Surgery/Outpatient Hospital Care in this **Appendix C, Exhibit 1**, as well as a clinic or office settings.

Diabetes Self-Management Training – Diabetes self-management training and education services furnished to an individual with pre-diabetes or diabetes by a physician or certain accredited mid-level provides (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).

Dialysis Services - Including laboratory; prescribed drugs; tubing change; adapter change; hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis; and training related to dialysis services.

Durable Medical Equipment and Medical/Surgical Supplies (See also **Appendix C, Exhibit 3**) –

1. **Durable Medical Equipment** - Products that: (a) are fabricated primarily and customarily to fulfill a medical purpose; (b) are generally not useful in the absence of illness or injury; (c) can withstand repeated use over an extended period of time; and (d) are appropriate for home use. Includes but not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, & rentals), walkers, commodes, special beds, monitoring equipment, and the rental of Personal Emergency Response Systems (PERS).

2. **Medical/Surgical Supplies** - Medical/treatment products that: (a) are fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) are used in the treatment of a specific medical condition; and (c) are nonreusable and disposable including, but not limited to, items such as urinary catheters, wound dressings, and diapers.

Emergency Services – Covered inpatient and outpatient services, including Behavioral Health Services, which are furnished to an Enrollee by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Family Planning – Family planning medical services, family planning counseling services, follow-up health care, outreach, and community education. Under Federal law, an Enrollee may obtain family planning services from any MassHealth provider of family planning services without the Contractor's authorization.

Group Adult Foster Care - Services ordered by a physician delivered to an Enrollee in a group housing residential setting such as assisted living, elderly, subsidized or supportive housing. Group Adult Foster Care services are based upon an individual plan of care and include assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight and care management. Assistance with ADLs, IADLs and other personal care is provided by a direct care worker that is employed or contracted by the Group Adult Foster Care provider, Nursing services and oversight and care management are provided by a multidisciplinary team.

Hearing Aid Services – Including but not limited to diagnostic services, providing and dispensing hearing aids or instruments; ear molds; ear impressions; batteries; accessories; aid and instruction in the use, care, and maintenance of the hearing aid; services related to the care and maintenance of hearing aids or instruments; and loan of a hearing aid to the Enrollee, when necessary.

Homeless Medical Respite — Medical respite services for individuals experiencing homelessness provided post-hospital discharge or hospital emergency department visit for medical or surgical issues or pre-procedure for colonoscopies. Post-hospital medical respite services include semi-private or private room and board; screening, intake and admission; assessment; care planning; case management; health referral and navigation; intensive housing navigation supports; and discharge planning. Pre-procedure medical respite services include private room and board; screening, intake and admission; pre-procedure support services; and discharge planning.

Home Health – All home health care services, including DME associated with such services; skilled and supportive care services provided to meet skilled care needs and associated activities of daily living to allow and support the member to safely stay in their home. Available services include part-time, intermittent, and continuous skilled nursing; medication administration; home health services including home health aide, and occupational, physical, and speech/language therapy; and medical social services. See 130 CMR 403.000 and MassHealth Home Health Agency Bulletin 54 (June 2019).

Hospice – A package of services such as nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aide; medical supplies, drugs, biological supplies; and short-term inpatient care. While an Enrollee is in hospice care, the Contractor shall pay for other cover services not related to the illness or condition for which they entered hospice care. The MassHealth Hospice benefit includes room and board for Enrollees receiving hospice in a nursing facility.

Inpatient Hospital Services — All inpatient services, including but not limited to physician, surgery, radiology, nursing, laboratory, obstetrics, other diagnostic and treatment procedures, blood and blood derivatives, semiprivate or private room and board, drugs and biologicals, medical supplies, durable medical equipment, medical surgical/intensive care/coronary care unit, as necessary. Inpatient Hospital Services also include Administratively Necessary Day (AND) Services, which is defined as a day of Inpatient Hospitalization on which an Enrollee's care needs can be provided in a setting other than the Inpatient Hospital and on which an Enrollee is clinically ready for discharge. As necessary, the services above shall be provided at any of the following settings:

1. acute inpatient hospital;
2. chronic hospital;
3. rehabilitation hospital; or
4. psychiatric hospital.

Laboratory – All services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees. All laboratories performing services under this Contract shall meet the credentialing requirements set forth in **Section 2.9.8**, including all medically necessary vaccines not covered by the Commonwealth of Massachusetts Department of Public Health.

Medical Nutritional Therapy – Nutritional, diagnostic, therapy, and counseling services for the purpose of a medical condition that are furnished by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited mid-level providers (e.g., registered nurses, physician assistants, and nurse practitioners).

Orthotics – Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. See Subchapter 6 of the Orthotics Manual for minimum MassHealth coverage requirements.

Oxygen and Respiratory Therapy Equipment – Ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.

Personal Care Attendant Services (Self-directed PCA) - (See also Personal Assistance Services in **Appendix C, Exhibit 3**.) Physical assistance with Activities of Daily Living (ADLs), including but not limited to bathing, dressing, grooming, eating, ambulating/mobility, toileting, transferring, medication administration, and passive range of motion exercise; and Instrumental Activities of Daily Living (IADLs), including but not limited to household management tasks, meal preparation, and transportation to medical providers. Individuals requiring physical assistance with two (2) or more ADLs meet clinical eligibility requirements to receive PCA services.

Pharmacy Covered Product – The term Pharmacy Covered Product means:

1. Any drug or biological that is used for a medically-accepted indication (as that term is defined in section 1860D2(e)(4) of the Act), and that is one of the following:

    a) A drug that may be dispensed only on a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1927(k)(2) of the Act;
    b) A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act; or
    c) Insulin described in section 1927(k)(2)(C) of the Act, and medical supplies associated with the delivery of insulin.

2. A vaccine licensed under section 351 of the Public Health Service Act and its administration.

3. Any drug or biological that would be covered, as prescribed and dispensed or administered, under Medicare Parts A or B.

4. Drugs excluded from Medicare Part D and over-the-counter products contained in the MassHealth Drug List.

5. Prescription vitamins and minerals contained in the MassHealth Drug List.

6. The products dronabinol, megestrol, oxandrolone, and somatropin for indications

not covered by Part D but covered under MassHealth.

7. Non-Drug OTC products contained in the MassHealth Non-Drug Product List that are not covered by Medicare Part B or Part D, including: Hyper-Sal (sodium chloride 7% for inhalation) and urine glucose testing reagent strips used for the management of diabetes.

Exclusions - The definition of Pharmacy Covered Product excludes the following drugs or biologicals or classes of drugs or biologicals, or their medical uses, unless otherwise specified in the MassHealth Drug List or MassHealth Non-Drug Product List:

1. **Cosmetic** – Drugs when used for cosmetic purposes, unless medically necessary;
2. **Cough and Cold** – Drugs when used for the symptomatic relief of cough and colds, unless dispensed to a member who is a resident in a nursing facility;
3. **Fertility** – Drugs when used to promote fertility;
4. **Less-than-effective Drugs** – Any drug products that the US FDA has proposed in a Notice of Opportunity for Hearing (NOOH) to withdraw from the market due to lack of substantial evidence of effectiveness for all labeled indications;
5. **Experimental and Investigational Drugs** – Drugs that are experimental, medically unproven, or investigational in nature; and
6. **Drugs for Sexual Dysfunction** – Drugs when used for the treatment of sexual dysfunction.

Physician (primary and specialty) — All medical, psychiatry, radiological, laboratory, anesthesia, and surgical services, including those services provided by nurse practitioners serving as primary care providers and services provided by nurse midwives. Physician services include annual exams and continuing care, as well as second opinions upon the request of the Enrollee.

Podiatry –Care for medical conditions affecting the lower limbs, including routine foot care as defined by Medicare in Part III, Section 2323 of the Medicare Carriers Manual. Services as certified by a physician, including medical, radiological, surgical, and laboratory care.

Prosthetics Services and Devices – Prosthetic devices, including the evaluation, fabrication, and fitting of a prosthesis. Coverage includes related supplies, repair, and replacement. See Subchapter 6 of the Prosthetics Manual for minimum MassHealth coverage requirements.

Remote Patient Monitoring (RPM) - The use of select medical devices that transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location, enabling the provider to respond to the patient and manage their condition. RPM is available to members who meet certain clinical criteria.

Radiology and Diagnostic Tests – All X-rays, including portable X-rays, magnetic resonance imagery (MRI), radiation therapy, and other radiological and diagnostic services, including those radiation or oncology services performed at radiation oncology centers (ROCs) which are independent of an acute outpatient hospital or physician service.

Skilled Nursing Facility/Nursing Facility Services - A wide range of services that result in individuals achieving or maintaining their "highest practicable" physical, mental, and psychosocial wellbeing. The services offered include 24 hour per day skilled nursing care; rehabilitative care, such as physical, occupational, speech, and respiratory therapy; and assistance with ADLs such as dressing and eating; pharmaceutical services; dietary and nutritional services; all psychosocial services such as mental health and therapeutic activities; and room and board. Coverage of nursing facility services includes both the initial period of a stay that Medicare would cover for a dual eligible individual or MassHealth would cover for a Medicaid-only Member and the long-term component (sometimes called "custodial care"). These services are not time limited for plan Enrollees. The Contractor shall ensure that its contracted nursing facilities establish and follow a written policy regarding its bed-hold period, covering at a minimum what is covered under the MassHealth bed-hold policy (see 130 CMR 456.425).

Therapy – Individual treatment, (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device); comprehensive evaluation; and group therapy.

1) Physical: evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems.

2) Occupational: Evaluation and treatment designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

3) Speech and Hearing: Evaluation and treatment of speech language, voice, hearing, and fluency disorders.

Tobacco Cessation Services – Face-to-face individual and group tobacco cessation counseling as defined at 130 CMR 433.435(B), 130 CMR 405.472 and 130 CMR 410.447 and pharmacotherapy treatment, including nicotine replacement therapy (NRT).

Transportation (Medical) – Including transportation in an ambulance (air and land) and other common carriers, for emergency and non-emergency transport:

Emergency Medical Transportation – ambulance (air and land) transport that generally is not scheduled, but is needed on an emergency basis, including Specialty Care Transport that is ambulance transport of a critically injured or ill

Enrollee from one facility to another, requiring care that is beyond the scope of a paramedic.

Non-Emergency Medical Transportation (NEMT) – This includes chair car, taxi, common carriers, and ambulance (land) services as needed that generally are pre-arranged to transport an Enrollee to a covered service that is located in-state or out-of-state. Any Covered Service or Flexible Benefit, or any other service or activity arranged by the Contractor pursuant to an Enrollee's Assessment and Care Plan, for which the Enrollee requires Transportation to access the service or activity, shall be considered within the scope of this NEMT service.

Urgent Care Clinic Services – Covered services provided by an urgent care clinic consistent with 130 CMR 455.000 and Section 39 of Ch. 260 of the Acts of 2020.

Vaccine Counseling Services – Immunization counseling by a physician or other qualified health care professional, including for COVID-19 vaccination.

Vision Care Services – The professional care of the eyes for purposes of diagnosing and treating all pathological conditions. They include eye examinations, vision training, prescription and dispensing of ophthalmic materials, ocular prosthesis, bandage lenses, other visual aids, and glasses and contact lenses.

Wigs – As prescribed by a physician related to a medical condition.

EXHIBIT 2: Behavioral Health Services

The Covered Services described in this Appendix represent minimum coverage scope for Enrollees under the MassHealth benefit for Medicaid coverage, and shall be provided in addition to coverage and scope available through Medicare Part A, Part B, and Part D.

A. Behavioral Health Inpatient Services - Twenty-four-hour (24) services, delivered in a licensed or State-operated hospital setting that provide clinical intervention for mental health or substance use diagnoses, or both. This service includes continuing inpatient psychiatric care delivered at a facility that provides such services as further specified by EOHHS. This service includes:

1. **Inpatient Mental Health Services** — Hospital services to evaluate and treat an acute psychiatric condition that: 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.

2. **Inpatient Substance Use Disorder Services (Level 4)** – Intensive inpatient services provided in a hospital setting, able to treat Enrollees with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credentialed physician and other appropriate credentialed treatment professionals with the full resources of a general acute care or psychiatric hospital available.

3. **Observation/Holding Beds** – Hospital services for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Enrollees.

4. **Administratively Necessary Day Services** - One or more days of inpatient hospitalization provided to Enrollees when said Enrollees are clinically ready for discharge but an appropriate setting is not available. Services shall include appropriate continuing clinical services.

B. Diversionary Services - Those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services: those provided in a 24-hour facility; and those which are provided in a non-24-hour setting or facility. **(See detailed services below.)**

I. 24-Hour Diversionary Services:

1. **Community Crisis Stabilization** – Community-based program that serves a medically necessary, less-restrictive alternative to hospitalization when clinically appropriate and provides continuous 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for

those with mental health and/or substance use disorders who do not require Inpatient Services. Stabilization and treatment include the capacity to provide induction onto and bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated).

2. **Medically Monitored Intensive Services** – **Acute Treatment Services (ATS) for Substance Use Disorders - (ASAM Level 3.7)** – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Withdrawal management services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: biopsychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant individuals receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in freestanding or hospital-based programs licensed by the Department of Public Health.
3. **Clinical Stabilization Services for Substance Use Disorders (ASAM Level 3.5)** – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive education and counseling, outreach to families and significant others; linkage to medications for addiction therapy, connection to primary care and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant individuals receive coordination of their obstetrical care. Clinical Stabilization Services for Substance Use Disorders programs must be licensed by the Department of Public Health.
4. **Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM Level 3.1);** *(Clinically Managed Low-Intensity Residential Services ASAM Level 3.1)*

    a. **Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) -** 24-hour residential environment that provides a structured and comprehensive rehabilitative environment that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu-based rehabilitative activities. Residential programs licensed and approved to serve pregnant and post-partum women provide assessment and management of gynecological and/or

obstetric and other prenatal needs, as well as treatment plans addressing parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Enrollees with Co-occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.

b. **Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) -** 24-hour residential environment for families in which a parent has a substance use disorder and either is pregnant, has custody of at least one child or has a physical reunification plan with at least one child within 30 days of admission. Scheduled, goal-oriented rehabilitative services intended to support parents and children are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal and parenting skills necessary to lead an alcohol and/or drug-free lifestyle and support family reunification and stability. Enrollees receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu-based rehabilitative activities.

c. **Co-occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)** - 24-hour, safe, structured environment, located in the community, which supports Enrollee's recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate. Programs will ensure that Members have access to prescribers of psychiatric and addiction medications.

d. **Pregnancy Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)** – 24-hour developmentally appropriate residential environment designed specifically for people who are pregnant that provides a structured and comprehensive rehabilitative environment for that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu-based rehabilitative activities. Residential programs must provide assessment and management of gynecological and/or obstetric and other prenatal needs, as well as treatment plans addressing parenting skills

education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups.

II. Non-24-Hour Diversionary Services:

1. **Certified Peer Specialist** – Mentoring, advocacy, and facilitation of support for Enrollees experiencing a mental health disorder, provided by self-identified persons with lived experience of a mental health disorder and wellness who has been trained by an agency approved by the Massachusetts DMH.

2. **Community Support Program (CSP)** - An array of services delivered by a community-based, mobile, multidisciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a longstanding history of a psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type, and intensity of services depending on the changing needs of the Enrollee. Specialized CSP programs serve populations with particular needs

   Specialized CSP Programs:

   a. **CSP for Homeless Individuals (CSP-HI)** – A Specialized CSP service to address the health-related social needs of Enrollees who (1) are experiencing Homelessness and are frequent users of acute health MassHealth services, as defined by EOHHS, or (2) are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. CSP-HI includes support searching for permanent supportive housing; preparing for and transitioning to an available housing unit; and coordinating access to health and other services to help the Enrollee sustain tenancy and meet their health needs.

   b. **CSP for Justice Involved (CSP-JI)** – A Specialized CSP service to address the health-related social needs of Enrollees with Justice Involvement who have a barrier to accessing or consistently utilizing medical and behavioral health services, as defined by EOHHS. CSP-JI includes behavioral health and community tenure sustainment supports.

   c. **CSP – Tenancy Preservation Program (CSP-TPP)** - A Specialized CSP service to address the health-related social needs of Enrollees who are At Risk of Homelessness and facing Eviction as a result of behavior related to a disability. CSP-TPP works with the member, the

Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation. The primary goal of the CSP-TPP is to preserve the tenancy and the secondary goals are to put in place services that address those issues that put the Enrollee's housing in jeopardy to ensure that the Enrollee's housing remains stable.

3. **Intensive Outpatient Program (IOP)** - A clinically intensive service designed to improve Functional Status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment. IOPs must be licensed by the Department of Public Health.

4. **Partial Hospitalization (PHP)** - An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.

5. **Program of Assertive Community Treatment (PACT)** – A multidisciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Enrollees to maximize their recovery, ensure Consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the Enrollees served become better integrated into the community. Services are provided in the community and are available, as needed by the Enrollee, 24 hours a day, seven days a week, 365 days a year.

6. **Psychiatric Day Treatment** - Services which constitute a program of a planned combination of diagnostic, treatment, and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual provider's office, or hospital outpatient department, but who does not need 24-hour hospitalization.
7. **Recovery Coaching –** A nonclinical service provided by an individual with at least two years of sustained recovery who holds, or is actively working to obtain, credentialing as a Certified Addiction Recovery Coach (CARC) through the Massachusetts Board of Substance Abuse Counselor Certification, or alternative licensure or certification process, as directed by EOHHS. Eligible Enrollees will be connected with Recovery Coaches at critical junctures in the Enrollees' treatment and recovery. The focus of the Recovery Coach role is to create a relationship between equals that is nonclinical and focused on removing obstacles to recovery, to facilitate initiation and engagement to treatment, and to serve as a guide and

motivating factor for the Enrollee to maintain recovery and community tenure. Peer recovery coaches must have lived experience with substance use and other addictive disorders, and/or co-occurring mental health disorders and has been trained to help their peers with similar experiences to gain hope, explore recovery, and achieve life goals.

8. **Recovery Support Navigators (RSN) -** A specialized care coordination service intended to engage Enrollees with Substance Use Disorder in accessing and continuing Substance Use Disorder treatment. RSNs may be located in a variety of Substance Use Disorder treatment environments, doing outreach and building relationships with individuals in programs, including withdrawal management and step-down services. If an Enrollee accepts RSN services upon leaving a Substance Use Disorder treatment program, the RSN will work with the individual on accessing appropriate treatment and staying motivated for treatment and recovery.

9. **Structured Outpatient Addiction Program (SOAP)** - Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Use Disorder Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant individuals and adults requiring 24hour monitoring and must be licensed by the Department of Public Health.

C. **Behavioral Health Outpatient Services –** Mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school. Standard Outpatient Services are most often provided in an ambulatory setting. **(See detailed services below.)**

1. **Family Consultation** – A meeting of at least 15 minutes duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.

2. **Case Consultation** - An in-person or by telephone meeting of at least 15 minutes duration, between the treating Provider and other behavioral health clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical

supervision or consultation with other clinicians within the same provider organization.

3. **Diagnostic Evaluation** - An assessment of an Enrollee's level of functioning, including physical, psychological, social, educational, and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.

4. **Dialectical Behavioral Therapy (DBT)** - A manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Enrollees with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.

5. **Psychiatric Consultation on an Inpatient Medical Unit** - An in-person meeting of at least 15 minutes duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.

6. **Medication Visit** - An individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.

7. **Couples/Family Treatment** - The use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and their partner and/or family simultaneously in the same session.

8. **Group Treatment** - The use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.

9. **Individual Treatment** - The use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.

10. **Inpatient-Outpatient Bridge Visit** - A single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.

11. **Acupuncture Treatment** - The insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are

withdrawing from dependence on substances or in recovery from addiction. Acupuncture services may also be provided for the treatment of pain as described in **Appendix C, Exhibit 1**.

12. **Opioid Treatment Services** - Supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses induction of Medication for Opioid Use Disorder (MOUD), withdrawal management, and maintenance treatment. MOUD services may also be provided by outpatient hospital emergency departments in accordance with the MassHealth Acute Hospital RFA as further specified by EOHHS

13. **Ambulatory Withdrawal Management (Level 2WM)** - Outpatient services for Enrollees who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.

14. **Psychological Testing** - The use of standardized test instruments to assess an Enrollee's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.

D. **Crisis Services** – Crisis services are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. **(See detailed services below)**

1. **Adult Mobile Crisis Intervention (AMCI)** - Each AMCI Encounter shall include at a minimum: crisis assessment, intervention and stabilization.

   a. Assessment - A face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;

   b. Intervention – The provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and

   c. Stabilization – Short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.

   d. In addition, medication evaluation and specialing services shall be

provided if Medically Necessary.

2. **Emergency Department-based Crisis Intervention Mental Health Services** - Behavioral health crisis interventions include the crisis evaluation, stabilization interventions, and disposition coordination activities for members presenting to the ED and on inpatient medical or surgical units in a behavioral health crisis. Elements of crisis evaluations include:

    a. **Crisis Evaluation**: Behavioral Health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Qualified behavioral health professionals include: qualified behavioral health professional, a psychiatrist, and other master's and bachelor's-level clinicians and staff sufficient to meet the needs of members served which may include certified peer specialists and recovery coaches.

    b. **Crisis Stabilization Interventions**: Observation, treatment, and support to individuals experiencing a behavioral health crisis.

    c. **Discharge Planning and Care Coordination**: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care.

E. **Other Behavioral Health Services** - Behavioral Health Services that may be provided as part of treatment in more than one setting type.

1. **Electro-Convulsive Therapy (ECT)** - A therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.

2. **Repetitive Transcranial Magnetic Stimulation (rTMS)** - A noninvasive form of neurostimulation in which rapidly changing magnetic fields are applied to the surface of the scalp through a copper wire coil connected to a magnetic stimulator. The therapeutic service is used to treat depression that has not responded to standard treatment such as medications and psychotherapy.

3. **Specialing** - Therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.

EXHIBIT 3: Additional Community-Based Services

Part A

The services listed in this **Exhibit 3, Part A** are the services described in the Frail Elder Waiver (**Appendix S** (of this Contract), Appendix C (of the Frail Elder Waiver)). These services differ from similar services described in **Appendix C, Exhibits 1 and 2** in amount, duration, scope, or other provider and Enrollee qualifications; they may also be in addition to the services described in **Appendix C, Exhibits 1 and 2**. The services listed in this **Exhibit 3, Part A** are available to SCO Enrollees in accordance with their Care Plan.

1. **Alzheimer's/Dementia Coaching**

2. **Assistive Technology for Telehealth**

3. **Chore**

4. **Companion** (to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health in **Appendix C, Exhibit 1**)

5. **Complex Care Training and Oversight** (formerly Skilled Nursing) (to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health or Continuous Skilled Nursing in **Appendix C, Exhibit 1**)

6. **Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)** (to the extent not covered under DME in **Appendix C, Exhibit 1**)

7. **Environmental Accessibility Adaptation**

8. **Evidence Based Education Programs**

9. **Goal Engagement Program**

10. **Grocery Shopping and Delivery**

11. **Home Based Wandering Response Systems** (*to the extent not covered under DME in **Appendix C, Exhibit 1***)

12. **Home Delivered Meals**

13. **Home Delivery of Pre-packaged Medication** *(to the extent not covered under Medicare Part D for Dual Eligible Individuals or Pharmacy Services in **Appendix C, Exhibit 1**)*

14. **Home Health Aide** (*to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health in **Appendix C, Exhibit 1**)*

15. **Home Safety/Independence Evaluations** (formerly Occupational Therapy) (*to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health or Independent Nursing in **Appendix C, Exhibit 1**)*

16. **Homemaker** (*to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health in **Appendix C, Exhibit 1**)*

17. **Laundry** (*to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health in **Appendix C, Exhibit 1**)*

18. **Medication Dispensing System** *(to the extent not covered under Medicare Part D services for Dual Eligible Individuals or Pharmacy Services or DME in **Appendix C, Exhibit 1**)*

19. **Orientation and Mobility Services**

20. **Peer Support** *(to the extent this is beyond Peer Supports available under Certified Peer Specialist or Recovery Coach in **Appendix C, Exhibit 2**)*

21. **Personal Care** (*to the extent available through an Agency Model rather than through the Self-Directed PCA Model in **Appendix C, Exhibit 1**)*

22. **Respite**

23. **Supportive Day Program** (*to the extent not covered under Adult Day Health or Day Habilitation in **Appendix C, Exhibit 1**)*

24. **Supportive Home Care Aide** (*to the extent not covered under Medicare for Dual Eligible Individuals, or Home Health in **Appendix C, Exhibit 1**)*

25. **Transitional Assistance**

26. **Transportation** (*to the extent not covered under Non-Emergency Medical Transportation (NEMT) in **Appendix C, Exhibit 1**)*

27. **Virtual Communication and Monitoring (VCAM)**

Part B - RESERVED

APPENDIX D
SCO PAYMENT

EXHIBIT 1: CCA SCO BASE CAPITATION RATES

CCA Base Capitation Rates effective January 1, 2026

Rating Category	Status	Region	Rates Effective 01/01/2026–12/31/2026
Institutional			
Institutional — Tier 1	Dual Eligible	Statewide	$7,097.81
	Medicaid Only	Statewide	$7,097.81
Institutional — Tier 2	Dual Eligible	Statewide	$9,045.91
	Medicaid Only	Statewide	$9,045.91
Institutional — Tier 3	Dual Eligible	Statewide	$10,096.69
	Medicaid Only	Statewide	$10,096.69
Community			
Community Other	Dual Eligible	Eastern	$722.90
	Dual Eligible	Western	$747.54
	Dual Eligible	The Cape	$654.27
	Medicaid Only	Eastern	$1,331.11

	Medicaid Only	Western	$1,373.20
	Medicaid Only	The Cape	$1,465.87
Community BH	Dual Eligible	Eastern	$914.73
	Dual Eligible	Western	$763.93
	Dual Eligible	The Cape	$746.91
	Medicaid Only	Eastern	$1,837.86
	Medicaid Only	Western	$2,396.41
	Medicaid Only	The Cape	$1,913.99
Community NHC	Dual Eligible	Eastern	$3,040.00
	Dual Eligible	Western	$3,204.00
	Dual Eligible	The Cape	$3,040.00
	Medicaid Only	Eastern	$4,560.00
	Medicaid Only	Western	$4,834.67
	Medicaid Only	The Cape	$4,879.55
Transition to Community			
Transition to Community	Dual Eligible	Statewide	$7,097.81

	Medicaid Only	Statewide	$7,097.81
Transition to Nursing Facility			
Transition to Nursing Facility	Dual Eligible	Eastern	$2,962.89
	Dual Eligible	Western	$3,106.98
	Dual Eligible	The Cape	$2,962.83
	Medicaid Only	Eastern	$4,334.77
	Medicaid Only	Western	$4,681.81
	Medicaid Only	The Cape	$4,725.27

APPENDIX D
SCO PAYMENT

EXHIBIT 2: DIRECTED PAYMENTS

Directed Payments effective January 1, 2026

Item Number	Type of Directed Payment	Program Name
1	Minimum fee schedule	Adult Day Health (ADH)
2	Minimum fee schedule	Day Habilitation
3	Minimum fee schedule	Adult Foster Care (AFC)
4	Minimum fee schedule	Personal Care Management (PCM)
5	Minimum fee schedule	Continuous skilled nursing (CSN)
6	Minimum fee schedule	Medicaid Covered Nursing Facility, Bariatric add-on, SUD add-on, Special Capacity add-on
7	Minimum fee schedule	Community Behavioral Health Centers
8	Minimum fee schedule	Community Support Program (CSP) - CSP Homeless Individuals, CSP -Tenancy Preservation, CSP - Justice Involved Individuals
9	Minimum fee schedule	Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services (CSS) for Substance Use Disorders (including Individualized Treatment Services)

10	Minimum fee schedule	Residential Rehabilitation Services (RRS) and Specialty RRS
11	Minimum fee schedule	Program of Assertive Community Treatment (PACT) services,
12	Minimum fee schedule	Adult Community Crisis Stabilization
13	Minimum fee schedule	Adult Mobile Crisis Intervention
14	Minimum fee schedule	BH Crisis Management in ED or Med/surgical inpatient floor Services
15	Minimum fee schedule	PCA Services
16	Minimum fee schedule	Ground Ambulance Rates
17	Minimum fee schedule	Group Adult Foster Care Services
18	Minimum fee schedule	Homeless Medical Respite (aka: Short Term Pre-procedure and Post Hospitalization)
19	Minimum fee schedule	Corrective Mobility Systems Repairs
20	Minimum fee schedule	Behavioral Health Urgent Care

APPENDIX E
SCO RISK SHARING ARRANGEMENTS

Contract Year 2026
Contract-Wide Risk Sharing Arrangement (Section 4.5)

1. **Overall Approach**

   a. For purposes of this section, the following terms shall have the following meanings:

      i. **Adjusted Medicaid Medical Expenditures** – an amount equal to the Medicaid portion of Adjusted Medical Expenditures (as described in **Section 4.5.2.2**).

      ii. **Medical Component of the Capitation Rate Payment** – the amount equal to the Target MLR percentage, as determined by EOHHS, of the Capitation Rate Payment, as described in **Section 4.5.3**.

      iii. **Medical Component of the Medicare Parts A and B Premium Payments** – the amount equal to 85% of the Medicare Part A and B premium payments received by the Contractor for the Contract Year.

      iv. **Adjusted Medicare Medical Expenditures** – an amount equal to the Medicare portion of Adjusted Medical Expenditures (as described in **Section 4.5.2.2**) excluding Medicare Part D.

      v. **Combined Medicare and Medicaid Revenue** – an amount equal to the Medical Component of the Capitation Rate Payment plus the Medical Component of the Medicare Parts A and B Premium Payments.

      vi. **Combined Adjusted Medical Expenditures** – an amount equal to the Adjusted Medicaid Medical Expenditures plus the Adjusted Medicare Medical Expenditures.

      vii. **Material Change** – a change that determines whether a risk sharing scenario is triggered or not triggered, including a change that results in recoupment instead of payment or payment instead of recoupment.

   b. EOHHS shall calculate the Contractor's expenditures using the Contractor's financial reports and encounters for the Contract Year as captured twelve (12) months after the close of the Contract Year, as described in **Section 4.5.4**. In the event that Medicare Parts A and B

Final Risk Adjustment is not finalized twelve (12) months after the close of the Contract Year, EOHHS may open the reconciliation process to capture the Medicare Parts A and B Final Risk Adjustment when the adjustment is finalized, if the Contractor's revised Medical Component of the Medicare Parts A and B Premium Payments or the Contractor's revised Adjusted Medicare Medical Expenditures results in a Material Change.

c. EOHHS shall calculate the following:

i. **Medicaid Gains/Losses**

To calculate whether the Contractor had Medicaid Gains or Medicaid Losses for the Contract Year, EOHHS shall subtract the Adjusted Medicaid Medical Expenditures from the Medical Component of the Capitation Rate Payment. If such difference is equal to an amount greater than zero, such difference shall be the Contractor's Medicaid Gains. If such difference is an amount less than zero, such difference shall be the Contractor's Medicaid Losses. If such amount equals zero, the Contractor shall have neither Medicaid Gains nor Medicaid Losses for the Contract Year.

ii. **Combined Gains/Losses**

To calculate whether the Contractor had Combined Gains or Combined Losses for the Contract Year, EOHHS shall subtract the Contractor's Combined Adjusted Medical Expenditures from the Contractor's Combined Medicare and Medicaid Revenue. If such difference is equal to an amount greater than zero, such difference shall be the Contractor's Combined Gains. If such difference is an amount less than zero, such difference shall be the Contractor's Combined Losses. If such amount equals zero, the Contractor shall have neither Combined Gains nor Combined Losses for the Contract Year.

2. **Shared Medicaid Gains**

a. If the absolute value of the Medicaid Gains is greater than 5% of the Medical Component of the Capitation Rate Payment, and the absolute value of the Combined Gains is greater than 2.5% of the Combined Medicaid and Medicare Revenue, the Contractor and EOHHS shall share Medicaid Gains as follows:

i. For the absolute value of Medicaid Gains that are less than or equal to 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 100% and the EOHHS share is 0%.

ii. For each additional percentage of the absolute value of Medicaid Gains that exceeds 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 5% and the EOHHS share is 95%.

b. The Contractor's shared Medicaid Gains payments to EOHHS shall not exceed the amount that would result in an absolute value of Combined Gains less than or equal to 2.5% of the Combined Medicare and Medicaid Revenue.

3. **Shared Medicaid Losses**

a. If the absolute value of the Medicaid Losses is greater than 5% of the Medical Component of the Capitation Rate Payment, and the absolute value of the Combined Losses is greater than 2.5% of the Combined Medicare and Medicaid Revenue, the Contractor and EOHHS shall share Medicaid Losses as follows:

i. For the absolute value of Medicaid Losses that are less than or equal to 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 100% and the EOHHS share is 0%.

ii. For each additional percentage of the absolute value of Medicaid Losses that exceeds 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 5% and the EOHHS share is 95%.

b. EOHHS's shared Medicaid Losses payments to the Contractor shall not exceed the amount that would result in an absolute value of Combined Losses greater than or equal to 2.5% of the Combined Medicare and Medicaid Revenue.

4. **No Shared Medicaid Gains or Medicaid Losses**

EOHHS and the Contractor shall not share Medicaid Gains or Medicaid Losses (i.e., the Contractor's share shall equal 100% and EOHHS' share shall equal 0%) when:

a. The absolute value of Medicaid Gains is less than or equal to 5% of the Medical Component of the Capitation Rate Payment.

b. The absolute value of the Medicaid Gains is greater than 5% of the Medical Component of the Capitation Rate Payment and the absolute value of Combined Gains is less than 2.5% of the Combined Medicare and Medicaid Revenue.

c. The absolute value of the Medicaid Losses is greater than 5% of the Medical Component of the Capitation Rate Payment and the absolute value of the Combined Losses is less than 2.5% of the Combined Medicare and Medicaid Revenue.

d. The absolute value of Medicaid Losses is less than or equal to 5% of the Medical Component of the Capitation Rate Payment.

APPENDIX F
SCO PLAN SPECIFIC APPROVALS

EXHIBIT 1 – Service Area

Commonwealth Care Alliance, Inc.
Contract Year 2026

The Service Area outlined below is contingent upon the Contactor meeting all Readiness Review requirements in each county. EOHHS reserves the right to amend this **Appendix F, Exhibit 1** to revise the Service Area based on final Readiness Review results or subsequent determinations made by EOHHS.

Any modifications of the below Service Area will require Enrollee notification consistent with **Section 2.12.2** of this Contract.

The Service Area described in this exhibit shall remain in effect for subsequent Contract Years unless amended.

The Plan's Service Area for the Contract number and PBP(s) described in **Exhibit 2** of this **Appendix F** is comprised of the following Massachusetts counties:

1. Bristol
2. Essex
3. Franklin
4. Hampden
5. Hampshire
6. Middlesex
7. Norfolk
8. Plymouth
9. Suffolk
10. Worcester

APPENDIX F
SCO PLAN SPECIFIC APPROVALS

EXHIBIT 2 – PBP Eligibility Criteria

Commonwealth Care Alliance, Inc.
Contract Year 2026

As described in **Section 2.3.3.3** of this Contract, the Contractor shall enroll SCO Dual Eligible individuals for Contract Year 2026 into its SCO Medicare Advantage Contract Plan Benefit Packages (PBPs) as follows:

Medicare Contract ("H number"): H2225

A. **H2225.001**: All Eligible Individuals

The above eligibility criteria shall remain in effect for subsequent Contract Years unless amended.

APPENDIX G
SCO BEHAVIORAL HEALTH SERVICES

EOHHS is providing this appendix based on current information. EOHHS will update this appendix as appropriate.

EXHIBIT 1 - MassHealth Community Behavioral Health Center (CBHC) List

CBHC	CATCHMENT AREA
North Suffolk Mental Health Association	Greater Boston
Cambridge Health Alliance	Boston/Cambridge
Cambridge Health Alliance	Malden/Medford/Revere
Boston Medical Center	Boston/Brookline
Riverside Community Care	Norwood
Aspire Health Alliance	South Shore
The Brien Center	Berkshires
Clinical Support Options	Greenfield
Clinical Support Options	Northampton
Behavioral Health Network (BHN)	Southern Pioneer
Center for Human Development	Southern Pioneer
Advocates	Metrowest
Clinical Support Options	North County
Community Healthlink	North County

CBHC	CATCHMENT AREA
Riverside Community Care	South County
Community Healthlink	Worcester
Eliot Community Health Services	North Essex
Beth Israel Lahey Behavioral Services	Lawrence
Vinfen	Lowell
Eliot Community Health Services	Tri-city
Child and Family Services	Southern Coast
High Point Treatment Center	Brockton
Bay Cove Human Services	Cape Cod
Fairwinds- Nantucket's Counseling Center	Nantucket
Child and Family Services	Fall River
Community Counseling of Bristol County	Taunton/Attleboro

[REMAINDER OF PAGE INTENTIONALLY BLANK]

EXHIBIT 2 – State Operated Community Mental Health Centers

Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402
John C. Corrigan Mental Health Center 49 Hillside Street Fall River, MA 02729
Mass. Mental Health Center 75 Fenwood Road Boston, MA 02115
Pocasset Mental Health Center 830 Country Road Pocasset, MA 02559

[REMAINDER OF PAGE INTENTIONALLY BLANK]

EXHIBIT 3 – State Operated Facilities Providing Inpatient Mental Health Services, Outpatient Behavioral Health Services, and Diversionary Behavioral Health Services

Type of Service/Appendix C Category	Provider Name	Location	NPI	Claim Form[1]	Service
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	UB04	Inpatient Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	UB04	Inpatient Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1194803288	UB04	Outpatient Services*
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	1500	Professional Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	1500	Professional Services
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Acute Treatment Services
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Clinical Support Services
Clinic services	Brockton Multi-Service Center	Brockton	1326155458	1500	Clinic

[1] Professional services are also billed for these programs on a 1500 claim form.

Clinic services	Mass Mental Health Center	Boston	1073638805	1500	Clinic

REMAINDER OF PAGE INTENTIONALLY BLANK]

EXHIBIT 4 - State-Owned DMH and DPH Hospitals

State Agency	Hospital Name	MassHealth Provider ID	Provides Continuing Inpatient Psychiatric Care
DMH	SC Fuller Mental Health Center	110000091G	No
DMH	Taunton State Hospital	110000084H	Yes
DMH	Worcester Recovery Center	110000091D	Yes
DPH	Lemuel Shattuck Hospital	110078189A/D	Yes
DPH	Tewksbury Hospital	110078185A	Yes
DPH	Western Massachusetts Hospital	110027398B/E	No
DPH	Pappas Rehabilitation Hospital for Children*	110078194D	No

[REMAINDER OF PAGE INTENTIONALLY BLANK]

EXHIBIT 5 – DMH Bulletin #19-01 (March 1, 2019)

DEPARTMENT OF MENTAL HEALTH

DIVISION OF CLINICAL AND PROFESSIONAL SERVICES

LICENSING DIVISION – BULLETIN #19-01

March 1, 2019

Clinical Competencies/Operational Standards for DMH Licensed Inpatient Facilities

This bulletin, and the attachments hereto are issued pursuant to Department of Mental Health (DMH) regulations 104 CMR 27.03(5)&(8), which provide that DMH "may establish clinical competencies and additional operational standards for care and treatment of patients admitted to facilities[2] licensed pursuant to 104 CMR 27.00, including for specialty populations." The purpose of this regulatory provision is to assist the Department in assuring that DMH licensed facilities have the capability to provide the level of care needed by individuals who meet criteria for inpatient hospitalization, thereby increasing access to services required by citizens of the Commonwealth.

The attached clinical competencies/standards were developed by a broad stakeholder group that included DMH clinical and licensing staff, representatives of DMH licensed facilities, public and commercial payers, and professional trade associations. They are intended as guidelines to inform practice and to provide a baseline for DMH licensing reviews of individual facility's compliance with licensing regulations. The competencies/standards cover the following areas:

- Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals
- OMITTED
- Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk
- Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD)
- Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

While it is expected that all facilities will generally be able to meet the clinical competencies/standards (including provision of services and equipment), it is not necessarily expected that each facility will have the resources or staff available at all times to meet all competencies and standards at all times, as circumstances within facility at any given time may limit its ability to be in compliance. Facilities must, however, have a plan in place to provide additional staff coverage or equipment as may be needed to facilitate admission of patients who require such coverage or equipment, and should be prepared to engage with public and commercial payers proactively as indicated.

[2] The term "facility" as used in this bulletin includes DMH licensed units within general hospitals.

The DMH Licensing Division will begin referring to the attached competencies/standards in its licensing reviews beginning May 1, 2019.

Questions regarding this bulletin should be directed to the DMH Licensing Division at 617-626-8117 or DMH.Licensing@massmail.state.ma.us.

Attachments:

Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals

OMITTED

Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)

Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

[REMAINDER OF PAGE INTENTIONALLY BLANK]

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Medical Conditions

Psychiatric Units within General Hospitals

Psychiatric units in general hospitals are expected to have the capability, or the ability to secure the capability within a reasonable period of time (in hours or, for very complex medical care needs, days), to provide necessary medical care to patients requiring inpatient psychiatric hospitalization who also have medical conditions requiring the following services.

Each inpatient psychiatric unit in a general hospital shall have policies to assure that it has the capacity to provide care for persons with the following medical needs or conditions. If resources are not immediately available for patients with certain medical conditions, the facility must have a plan to secure the resources necessary to provide the care (e.g., securing "just in time" training for nurses from a specialty nurse educator, availability of a specialist to consult with the attending psychiatrist, etc.) through training, supplemental staff, etc. within a reasonable period of time:

- Intravenous (IV) hydration
- Continuous Positive Airway Pressure (CPAP)
- Diabetes Care
- Oxygen Therapy
- Alcohol Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Opiate Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Methicillin-resistant Staphylococcus aureus (MRSA) or other antibiotic-resistant infections or communicable infections
- Assistive devices/specialty equipment (e.g., walkers, canes, wheelchairs, hospital beds, specialty mattresses)
- Occupational Therapy (OT)/ Physical Therapy (PT)
- Anticoagulation therapies
- Eating disorders

- Incontinence
- Foley catheter
- Ostomy care
- Seizures – History and/ or risk of
- Respiratory conditions
- Wound care (any stage)
- Patient in need of in-house Lab services
- Patient in need of internal medicine resources on site

Each facility shall ensure that all staff designated to provide the listed services receive education and demonstrate competencies (i.e., upon hire, as needed, and/ or annually) that are consistent with their role in patient care regarding the above competencies. Each facility shall further ensure that medical and nursing care staff are trained in and can demonstrate knowledge of the facility's policy or plan for securing the resources necessary to provide the listed services and to provide just-in-time training to all staff who will provide care to the patient being admitted.

DMH recognizes that some capabilities may be beyond the capacity of certain general inpatient units within general hospitals. It is necessary; however, that these capabilities be present within the Commonwealth's hospital system, even if they may require extra resources, transportation or preparation. Facilities are encouraged to develop these capabilities, either through direct service arrangements, affiliations with outside providers or otherwise. These capabilities include, but are not limited to:

- IV medications
- Bilevel Positive Airway Pressure (BiPAP)
- Dialysis
- Suction
- Nasogastric (NG) Tube
- Eating disorders – severe restrictive or purging
- Pregnancy

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of

additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - ***Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization and who present with high level of acuity, including severe behavior and assault risk.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide treatment to patients with severe behavior/assault risk, including evaluating patients during the intake and admissions process to determine if additional staffing supplementation is required.

- Adjust staffing levels to meet varying levels of unit acuity.

- Evaluate and document care needs during the referral and acceptance process which serves as preparation for direct care staff and others to incorporate risk and individualized crisis prevention planning (ICPP) upon admission. (While safety tools are generally completed within 48 hours of admission, a person admitted with this risk level should have their safety tool or ICPP completed as soon as possible after arrival.)

- Provide a range of intervention approaches to address the needs of patients with higher levels of acuity. Aggressive, assaultive patients may benefit from behavior management plans, anger management, relaxation techniques, occupational therapy, and social skills development. Consideration for consultation with behavior specialists should be given.

- Provide ongoing training and demonstration of competencies in verbal de-escalation, including hands on experience, to reduce likelihood of harm.

    De-escalation and Preventative Skills that can assist direct care staff to safely respond to patient agitation or aggression include but are not limited to:

    - Motivational Interviewing
    - Trauma Informed Care
    - Person-Centered Approaches
    - Stigma/ Countertransference
    - Mindfulness
    - Flexible Rules
    - Strength-based interventions

    - Approachability of staff for providing help
    - Anger Management
    - Leadership Rounds regularly on units

- Security specialists/ guards who may participate in direct interactions with patients experiencing episodes of severe behavior or assault risk should have training (e.g., CPI, Handle With Care, MOAB) that is consistent with training received by the direct care psychiatric inpatient staff, as should any additional staff who may participate in such episodes.

- Ensure robust debriefing processes, including incidents that qualify as “near misses.”

- Provide Medication Management with proactive use of PRNs and use of withdrawal protocols as indicated.

- Ensure that staff on all shifts have access to Sensory Tools, and the training required to select and work with patients to use these tools as coping skills and methods for decreasing frustration and aggression.

- Involve community treaters, state agency representatives, and the legal system (if involved) in treatment and discharge planning as soon as possible after admission in order to assess the patient’s current continuum of care and foster successful outcomes.

- Ensure that wraparound community services are in place (e.g., get/fill medications, an outpatient medication/injection clinic (if needed), access transportation to appointments, stable housing, and case management).

- Engage patients who are identified as having “personality disorders or traits,” utilizing Trauma Informed Care (TIC), Motivational Interviewing (MI), Sensory Tools, attention to diet (e.g., polydipsia, excessive caffeine or sugar intake), and Mindfulness Training.

- Work with court system, families and/ or guardians to expedite the process of commitment if necessary.

- Provide increased security presence, specialized psychopharmacology interventions, and active treatment with the patient to identify and practice greater behavioral control skills.

- Ensure all staff receive consistent education and maintain current trainings and certifications (i.e., upon hire, as needed, and annually) to work with and care for these patients.

Each general inpatient psychiatric facility is recommended to consider:

- When possible, create flexibility in the physical plant for non-restraint and seclusion management of behavior. This can involve providing special observation/single rooms and higher staffing ratios for patients requiring assault precautions to mitigate the risk to roommates and other patients on the unit. It is ideal that a unit be able to provide a distinct, spacious area for the most acute patients with specialized group programming, activity space,

and comfort space (if possible). Patients could move to the regular section of the milieu when able to tolerate more stimulation.

- Consideration should be given to the inclusion of Peer Support Specialists in milieu treatment.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See ***DMH Licensing Bulletin #18-01 - Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ID/DD)

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization, who present with Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD), but who do not require specialized treatment due to their ASD/ID/DD beyond the competencies listed below.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide care to patients with mild to moderate presentations of Autism Spectrum Disorder or other intellectual and/or developmental disabilities whose baseline level of functional impairment is mild to moderate as well. Patients with significant maladaptive behavior, inability to maintain ADLs, as well as those with significant self-injurious or violent behavior, due to their ASD/ID/DD may have needs that exceed the expected capability of a general inpatient psychiatric unit.

- Recognize the clinical needs of common co-occurring physical conditions that are associated with many patients with ASD/ID/DD (e.g., severe constipation, diarrhea, urinary tract infections, food allergies, etc.).

- Provide sensory supports for varying levels of functioning.

- Ensure all staff receive consistent education and maintain current trainings (i.e., upon hire, as needed, and annually) to work with and care for this population.

- Provide ongoing trainings and demonstration of competencies in de-escalating behaviors of patients with ASD/ID/DD, as part of the general de-escalation program.

- Evaluate and document care needs during the referral and acceptance process, and use this information to incorporate the inclusion of behavioral triggers/warning signs, as well as strengths, motivators and any sensory tools that have been successfully employed for direct care staff and the multidisciplinary team.

- Notify and collaborate with the Department of Developmental Services, as appropriate and with the Department of Education (DOE), town or city special education departments to ensure the continuity of special education services for eligible students.

- Engage the Children's Behavioral Health Initiative (CBHI) teams, Department of Education (DOE) teams, DMH, and/or DDS for consultation and discharge planning as needed.

- Minimize the difficulty with transitions, especially by providing discharge information to care

managers and outpatient services. Ideally, the same team members (both inpatient and outpatient) would work with these patients as they move across the care continuum.

- Work with families and other caregivers before discharge to enhance successful transition of level of care and reduce recidivism.

Each general inpatient psychiatric facility is recommended to consider:

- Flexible availability of a separate, designated, less stimulating space is best.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 **-** ***Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Substance Use Disorders (SUD)

The Department of Public Health Bureau of Substance Addiction Services (BSAS) licenses inpatient psychiatric facilities that also provide a separate, identifiable inpatient SUD treatment program. Such units/ facilities are required to be dually licensed by DMH and BSAS.

A DMH licensed facility that provides SUD treatment or services, such as medication assisted treatment (MAT), incidental to the evaluation, diagnostic and treatment services for which it is licensed under 104 CMR 27.00, and that does not offer a separate, identifiable inpatient substance use disorder treatment unit or program, or represent themselves to the public as providing substance use disorder treatment or services as a primary or specialty service, must comply with DMH licensing requirements at 104 CMR 27.03(11) but is not subject to BSAS licensure requirements.

As part of its licensure obligations under 104 CMR 27.00, each inpatient psychiatric facility that is not subject to BSAS licensure shall assure that it has the capacity to:

- Identify potential for addictive disorders through evidence-based screening and assessment tools during the admission assessment process.

- Evaluate for, order, assess, and provide medication assisted treatments for alcohol, benzodiazepine, and opioid withdrawal and for addictions to these substances within limitations of licensure. Medication assisted treatment, education, orientation, and initiation is required when clinically indicated. (See SAMHSA Treatment Improvement Protocol 63 – Medications for Opioid Use Disorder)

  - This includes:

    - Assessing the patient for the appropriateness of induction on MAT using one of the three FDA-approved medications for the treatment of Opioid use disorder: buprenorphine, methadone, or naltrexone; and

    - Ensuring that once an induction begins, referrals for an outpatient provider (ex. OTP, OBOT) are secured.

  - Any physician or other authorized hospital staff in DMH-licensed inpatient facilities can administer or dispense methadone and buprenorphine without additional state or federal oversight or approval, provide the methadone or buprenorphine is administered or dispensed incident to the patient's medical treatment for a condition other than substance use disorder. This includes MAT induction for a patient with a secondary diagnosis of substance use disorder on either methadone or buprenorphine.

        - DEA regulations[3] authorize physicians or other authorized hospital staff to administer or dispense buprenorphine or methadone in the hospital, which includes psychiatric hospitals, in order to maintain or detox a patient "as an incidental adjunct to medical or surgical treatment of conditions other than addiction". In effect, this allows a physician or other authorized hospital provider to administer or dispense MAT to patients at the hospital, without time limitation, where SUD is a secondary diagnosis.

    - Practitioners who are DATA- waived[4] can prescribe, administer, or dispense buprenorphine to patients in DMH-licensed inpatient facilities.

- Administer opioid antagonist, if needed. All units must have naloxone available on unit and staff trained to order/administer.

- Provide group and/ or individual therapeutic programming and patient education, provided by appropriately trained staff, which addresses recovery and relapse prevention planning related to SUD. Engage, inform, and support parents and guardians of minors with SUD (on adolescent units). Suggested training for staff may include effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery.

- Provide active discharge planning to next step placements based on the patient's care plan. Placements should address ongoing needs related to mental health, addiction, and other biopsychosocial needs and may include step down to subacute levels of care, 24-hour settings, partial hospitalization, intensive outpatient, ongoing outpatient treatment, access to peer services, and other community and housing supports as appropriate. When appropriate, discharge planning must include access to ongoing medication management, both for psychiatric and addiction medications; for continuity of treatment with the goal of reducing readmissions and the likelihood of relapse. This includes having knowledge of Clinical Stabilization/Stepdown Services (CSS) and Transitional Support Services (TSS), Outpatient Medication Management, Sober Houses, and step down to subacute level of care.

- Understand deterrents to successful discharges such as housing, financial assistance for medication copayments, transportation to non-24-hour programs, applying for a prescription for transportation PT-1 form for those with financial issues, etc.

- Ensure a physician dispenses buprenorphine or morphine at discharge or a DATA-waived

[3] 21 CFR Part 1306.07. Note that these regulations also include the "three-day rule", which allows any physician to administer methadone or buprenorphine without additional state or federal oversight or approval. This includes MAT induction for a patient being treated for acute withdrawal symptoms. The rule allows MAT treatment to relieve acute withdrawal symptoms, provided the treatment is limited to 72 hours where not more than one day's medication is administered to a person at a time. The 72-hour period cannot be renewed. For more information, see 21 CFR Part 1306.07(b).

[4] The Drug Addiction Treatment Act (DATA) of 2000 authorized physicians to dispense or prescribe buprenorphine in settings other than an opioid treatment program (OTP), subject to certain limitations. This has subsequently been expanded to also authorize nurse practitioners and physician assistants to dispense or prescribe buprenorphine, subject to certain limitations. Information on the process for submitting a waiver to SAMHSA and the DEA can be accessed here: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

practitioner provides “bridge” prescriptions for buprenorphine (and other medications) until outpatient appointments can be secured and prescriptions provided for in the outpatient setting.

- Provide direct care staff with a general overview of addictions medicine.

Each inpatient psychiatric facility is recommended to:

- Facilities are strongly encouraged to provide access to all FDA-approved medications for the treatment of opioid use disorder.

- Consider engaging Substance Use Recovery Coaches and/or Peer Specialists within staffing models.

- Include credentialed staff with experience in SUD treatment and resources, ideally, but not necessarily as Licensed Alcohol and Drug Abuse Counselor (LADC) or Certified Alcohol and Drug Abuse Counselor (CDAC) levels.

- Consider referrals to ensure a continuum of care for the client, including arrangements for further substance abuse treatment and post-discharge counseling and other supportive service.

- Consider entering into formal agreements (Qualified Services Organization Agreement - QSOA’s) with community-based Substance Use Disorder treatment providers to support continuation of care.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director’s physician designee when unavailable* to exceed the facility’s capability at the time admission is sought. The medical director’s determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - ***Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director’s physician designee must be a physician who is vested with the full range of the medical director’s authority and responsibility in the medical director’s absence.

[REMAINDER OF PAGE INTENTIONALLY BLANK]

EXHIBIT 6 - Reserved

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
ENTERPRISE DATA MANAGEMENT & ENGINEERING

PAID ENCOUNTER DATA SET REQUEST

Version 5.0

August 2023

Revision History

For the updates prior to V 4.13 refer to V 4.12 of the document

Version	Date	Revision	Name
V 5.0	July – August 2023	1. Member and Member Enrollment (Segment 9 - Appendices): • Appendix C– Member File and Member Enrollment File Specifications – extracted and relocated to a separate Member Specs document • Appendix D – Member Data Values Reference Information - extracted and relocated to a separate Member Specs document	Alla Kamenetsky Dipika Budhathoki
V 4.13	March – June 2023	1. Member data set: extended the file format, added values, updated requirements and validation rues. 2. Claims data set: • Record Indicator (Field 4): added new values of 8 and 9 and a table with the examples. • Claim Number (field #5): length increased to 25 characters • Former Claim Number (field # 77): length increased to 25 characters • Quantity (field #36): addition to description • Gross Payment Amount (field # 61): addition to description • Dispensing Fee (field #67): addition to description • Provider Payment (field #232): added clarification • Service Category Table: Tables I-B1, I-B2, and I-C got replaced with Table I-B, which contains values for SCO and One Care reporting groups • Added new value to Table G “Servicing Provider Type” for Community Behavioral Health Center 3. Provider data set: • National Provider Identifier NPI (field #26): added clarification • Provider File Acceptance Requirements: added • PCC Provider ID Type (#31) if PCC Provider ID is not null PCC Provider ID Address Location Code (#37) if PCC Provider ID is not null	Alla Kamenetsky Dipika Budhathoki

CONTENTS

REVISION HISTORY ..... - 2 -
1 ..... - 2 -
ACRONYMS ..... - 5 -
1.0 INTRODUCTION ..... - 6 -
1.1 DATA REQUIREMENTS ..... - 6 -
1.2 HOW TO USE THIS DOCUMENT ..... - 8 -
2.0 DATA ELEMENT CLARIFICATIONS ..... - 9 -
2.1 RECORD TYPE SUBMISSION OPTIONS AND EXPLANATIONS ..... - 9 -
2.2 CLAIM NUMBER AND SUFFIX ..... - 10 -
2.3 MEMBER IDS ..... - 10 -
2.4 PROVIDER IDS ..... - 10 -
2.5 NPI ..... - 10 -
2.6 DRG ..... - 11 -
2.7 DIAGNOSIS CODES ..... - 11 -
2.8 PROCEDURE CODES ..... - 11 -
2.9 CAPITATION PAYMENTS ..... - 12 -
2.10 DOLLAR AMOUNTS ..... - 12 -
2.11 CLAIM NUMBER & SUFFIX ..... - 16 -
2.12 FORMER CLAIM NUMBER & SUFFIX ..... - 16 -
2.13 RECORD CREATION DATE ..... - 17 -
2.14 MASSHEALTH INPATIENT VS. OUTPATIENT CLAIM DETERMINATIONS ..... - 17 -
2.15 LTC CLAIMS ..... - 17 -
2.16 PHYSICIAN-ADMINISTERED DRUG CLAIM DEFINITION ..... - 18 -
2.17 ADMINISTRATIVE FEES ..... - 18 -
2.18 BUNDLE INDICATOR, CLAIM NUMBER & SUFFIX ..... - 18 -
2.19 SUBMISSION CLARIFICATION CODE ..... - 19 -
2.20 PROVIDER ID SUBMISSION IN ENCOUNTER AND PROVIDER FILES ..... - 20 -
2.21 MEDICARE RELATED DATA ..... - 20 -
2.22 PROGRAMS WITH WITHHOLD AMOUNT ..... - 20 -
2.23 RECOVERIES ..... - 21 -
3.0 ENCOUNTER DATA SET ELEMENTS WITH RECORD LAYOUT ..... - 22 -
3.1 PROVIDER FILE DATA SET WITH RECORD LAYOUT ..... - 48 -
3.2 MCE INTERNAL PROVIDER TYPE DATA SET ELEMENTS WITH RECORD LAYOUT ..... - 54 -

3.3 PROVIDER SPECIALTY DATA SET ELEMENTS ..... - 55 -
3.4 ADDITIONAL REFERENCE DATA SET ELEMENTS (MBHP ONLY) ..... - 56 -
4.0 ENCOUNTER RECORD LAYOUT AMENDMENT PROCESS AND LAYOUT ..... - 59 -
5.0 ERROR HANDLING ..... - 60 -
ERROR CODES ..... - 60 -
6.0 MEDIA REQUIREMENTS / ENCOUNTER CLAIMS FILES SUBMISSION REQUIREMENTS ..... - 64 -
6.1 FORMAT ..... - 64 -
6.2 REGULAR MONTHLY ENCOUNTER FILE SUBMISSION ..... - 64 -
6.3 PROJECT RELATED FILENAME ..... - 65 -
6.4 THE MANUAL OVERRIDE FILE ..... - 65 -
6.5 ZIP FILE ..... - 65 -
6.6 METADATA FILE ..... - 66 -
6.7 SECURE FTP SERVER ..... - 67 -
6.8 SENDING ENCOUNTER DATA ..... - 67 -
6.9 RECEIVING ERROR REPORTS ..... - 68 -
7.0 STANDARD DATA VALUES ..... - 69 -
TABLE A – Type of Admission (UB) ..... - 70 -
TABLE B – Source of Admission (UB) ..... - 71 -
TABLE C – Place of Service (HCFA 1500) ..... - 72 -
TABLE D – Type of Bill (from UB Bill Type – 1st & 2nd digits) ..... - 77 -
TABLE E – Discharge Status (UB Patient Status) ..... - 80 -
TABLE G – Servicing Provider Type ..... - 82 -
TABLE H – Servicing Provider Specialty (from CMS 1500) ..... - 91 -
TABLE I – A: Service Category (Using the 4B reporting groups) ..... - 98 -
Table I-B: Service Category (Using SCO and One Care reporting groups) ..... - 100 -
TABLE K – Bill Classifications - Frequency (3rd digit) ..... - 102 -
TABLE M – Present on Admission (UB) ..... - 104 -
TABLE O – UNIT OF MEASURE ..... - 105 -
8.0 QUANTITY AND QUALITY EDITS, REASONABILITY AND VALIDITY CHECKS ..... - 106 -

Acronyms

Acronym	Meaning
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan (MCE that submits encounter claims to MassHealth on behalf of Model A ACOs).
DS	MassHealth Data Strategy
DUA	Data Use Agreement
DW	Data Warehouse
EDME	Enterprise Data Management & Engineering (former Data Warehouse)
EOHHS	Executive Office of Health and Human Services
FFSE	Fee-For-Service-Equivalent. The amount that would have been paid by the MCE for a specific service or encounter on a fee for service basis if the service or encounter had not been capitated, paid under a bundled payment, paid partially (such as a withhold), overpaid to be recouped later, or otherwise paid under a risk sharing arrangement.
ICO	One Care Plans
MBHP	Mass Behavioral Health Partnership
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PCC	Primary Care Center
PHI	Protected Health Information
PIDSL	Provider ID Service Location
PII	Personally Identifiable Information
RELD SOGI	Race, Ethnicity, Language, Disability, Sexual orientation, and Gender identity
SCO	Senior Care Organization
SFTP	Secure File Transfer Protocol

1.0 Introduction

MassHealth Data Warehouse (MH DW) was required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in managed care programs. EHS is using the data for many critical workstreams, including Centers for Medicare and Medicaid Services (CMS, formerly HCFA) reporting, program evaluation, Monthly report production, financial determinations, risk/premium adjustment, performance evaluation in quality measures and utilization, and rate development. It is critical that each Managed Care Entity (MCE), ACO/MCO, MBHP, SCO, and One Care, provides MH DW with encounter claim records accurately reflecting all covered services provided to Medicaid recipients enrolled in MCEs' managed care program and the total medical cost of care. Only with complete and accurate encounter data can MassHealth fairly assess the effectiveness of MCEs and the managed care program.

All MCEs are required to submit complete, accurate, and timely encounter information on paid claims and related data. Unless otherwise directed by MassHealth, encounter claims are expected to reflect the MCE's actual payment or a Fee-for-Service-Equivalent (FFSE) for the MCE's medical cost of care for the encounter or service as it would be reflected in the MCE's financial reports (excluding IBNR). With the implementation of the ACO project, encounters for both, MCO and ACO, should be submitted in the same file.

For denied claims submissions, please see denied claims submission requirements specifications document.

These specifications provide the requirements for the Paid Encounter file and Provider files. All the MCEs, including SCO and One Care, should follow the same format of the files in their submissions.

For the Paid Encounter file submission requirements, please see section 6.0.

MassHealth expects the MCEs to provide new, replacement, and void claims in each submission. MassHealth processes the data and returns rejected claims to the MCEs with the appropriate error codes. MCEs are generally expected to correct the offending claims and send them in a correction file within 5 business days from the date the error reports are posted on SFTP server. The submission-rejection-resubmission cycle must be completed within a month of submission. The number of rejected claims must be below a MassHealth defined threshold. If you cannot submit data in this fashion, or if you have any questions about any of these documents, please send us an email at "EHS-DL-ENCSPECS@@MassMail.State.MA.US".

1.1 Data Requirements

- The data referred to in this document are encounter data – a record of health care services, health conditions and products delivered for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a visit with a unique set of services/procedures performed for an eligible recipient. Each service should be documented on a separate encounter claim detail line completed with all the data elements including date of service, revenue and/or procedure code and/or NDC number, units, and MCE payments/cost of care for a service or product.

- All encounter claim information must be for the member identified on the claim by Medicaid ID. Claims must not be submitted with another member's identification (e.g., newborn claims must not be submitted under the Mom's ID).

- All claims should reflect the final status of the claim on the date it is pulled from the MCE's Data Warehouse.

- For MassHealth, only the latest version of the claim line submitted to MassHealth is "active". Previously submitted versions of claim lines get offset (no longer "active" with MassHealth) and payments are not netted.

It is expected that providers will generally "roll up" their claim lines, having one claim line per service with the Quantity field (#36) indicating the number of service units the Member received.

- A Paid encounter is a fully adjudicated claim (with all associated claim lines) where the MCE incurred the cost either through direct payment or sub-contracted payment. Generally, at least one line would be adjudicated with a payment. All adjudicated claims must have a complete set of billing codes. There may also be fully adjudicated claims where the MCE did not incur a cost but would otherwise like to inform MassHealth of covered services provided to Enrollees/Members, such as for quality measure reporting (e.g., CPT category 2 codes for A1c lab tests and care/patient management).

- All claim lines should be submitted for each Paid claim, including zero paid claim lines (e.g., bundled services paid at an encounter level and patient copays that exceeded the fee schedule). Denied lines should not be included in the Paid submission. Submit one encounter record/claim line for each service performed (i.e., if a claim consisted of five services or products, each service should have a separate encounter record). Pursuant to contract, an encounter record must be submitted for all covered services provided to all enrollees. Payment amounts must be greater than or equal to zero. There should not be negative payments, including on voided claim lines.

- Records/services of the same encounter claim must be submitted with same claim number. There should not be more than one active claim number for the same encounter. All paid claim lines within an encounter must share the same active claim number. If there is a replacement claim with a new version of the claim number, all former claim lines must be replaced by the new claim number or be voided. The claim number, which creates the encounter, and all replacement encounters must retain the same billing provider ID or be completely voided.

- Plans are expected to use current MassHealth MCE enrollment assignments to attribute Members to the MassHealth assigned MCE. The integrity of the family of claims should be maintained when submitting claims for multiple MCEs (ACOs/MCO). Entity PIDSL, New Member ID, and the claim number should be consistent across all lines of the same claim.

- Data should conform to the Record Layout specified in Section 3.0 of this document. Any deviations from this format will result in claim line or file rejections. Each row in a submitted file should have a unique Claim Number + Suffix combination.

- A feed should consist of new (Original) claims, Amendments, Replacements (a.k.a. Adjustments) and/or Voids. The replacements and voids should have a former claim number and former suffix to associate them with the claim + suffix they are voiding or replacing. See Section 2.0, Data Element Clarifications, for more information.

- While processing a submission, MassHealth scans the files for the errors. Rejected records are sent back to the MCEs in error reports in a format of the input files with two additional columns to indicate an error code and the field with the error.

- Unless otherwise directed or allowed by MassHealth, all routine monthly encounter submissions must be successfully loaded to the MH DW between the 10th and the last day of each month with corrected rejections successfully loaded within 5 business days of the subsequent month for that routine monthly encounter submission to be considered timely and included in downstream MassHealth processes. Routine monthly encounter submissions should contain claims with dates of service and paid/transaction dates through the end of the previous month.

1.2 How to Use this Document

This Encounter Data Set Request is intended as a reference document. Its purpose is to identify the data elements that MassHealth needs to load into encounter database. The goal of this document is to clarify the standard record layout, format, and values that MassHealth will accept.

Data Element Clarifications

In 2.0 “Data Set Clarification” section provides clarifications and expectations on data elements like DRG, Diagnosis Codes, Procedure Codes, and Provider IDs.

Data Elements

The information contained in the Data Elements sections defines each of the fields included in the record layout. When appropriate, a list of valid values is included there. Nationally recognized coding schemes have been used whenever they exist.

Encounter Record Layout

Section 4.0 “Encounter Record Layout” specifies encounter file layout. All the MCEs must use that format when compiling the Encounter Data file that might contain all or any Claim Category (facility, professional, dental, etc.). MassHealth requests that the encounter data file is provided in a pipe-delimited text file with each service on a separate line.

Contact MassHealth if you need further clarification.

Media Requirements and Data Formats

Section 6.0 “Media Requirements and Data Formats.” contains complete information about all the files that should be submitted to EOHHS MassHealth Data Warehouse EHS DW. MCEs submit their data to MassHealth through a secure FTP server. Each MCE has a home directory on this server and is given an ID with public key/private key-based login. Please also note the security requirements for Internet transmissions noted in the Media Requirements section.

Standard Data Values

Section 7.0 “Standard Data Values” contains tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks

Section within 8.0 “Quantity and Quality Edits, Reasonability and Validity Checks” provides the validity and quality criteria that encounter data are expected to meet. Other Data Quality checks are noted in the Provider file section.

NOTE: MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCEs, even if the records are currently not rejected for missing or invalid values in some fields. MassHealth reserves the right to introduce additional completeness validation rules.

2.0 Data Element Clarifications

MassHealth has identified several data elements that require further clarification with respect to the expectations for those elements. The information in this section details MassHealth's expectations for Recipient Identifiers, Provider IDs, DRG, Diagnosis Codes (primary through fifth), and Procedure Codes.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE.

2.1 Record Type Submission Options and Explanations

Choose the correct Record Type for each claim line depending on the use case. Note the Special Submission requirements. Use care to ensure that all claim lines within a claim share the identical claim number after any adjustments.

Record Type	A.K.A.	Use	Special Submission Requirements
O = Original	Original	Initial submission of the claim	No special requirements
A = Amendment	Correction	To correct, update, add missing data elements values of a claim previously loaded in MH DW. Example: an incorrect data mapping to an Encounter field was remediated and impacted claim lines are now resubmitted to the MHDW with an "Amendment" Record Type and the correct value.	Submitted with the Original Claim Number and Suffix Nothing should be entered in Former Claim / Suffix Number fields unless the amendment is for a previously adjusted claim, in which case the amendment record would inherit the former claim number/suffix from the claim it is amending.
V = Void or Back Out	Void	To remove a claim line that was previously loaded in MH DW. Example: A paid claim was later denied. All previously submitted claim lines would be resubmitted with a "Void" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim to be voided must be placed in Former Claim Number/Suffix fields
R = Replacement	Adjustment	To replace a claim that was previously loaded in the MH DW with one that has a new claim number. Example: the provider has resubmitted a claim under a new claim number. All previously submitted claim lines must be resubmitted with the new claim number and a "Replacement" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim that has to be replaced must be placed in Former Claim Number/Suffix fields. All claim lines need to be replaced with the new claim number. If there are more claim lines in the replacement claim than the original, submit the additional claim as an Original. Visa versa, if there are fewer claim lines in the replacement than the original, void the extra claim lines.

2.2 Claim Number and Suffix

Every Original / Void or Replacement claim submitted to MassHealth should have a new, unique claim number + suffix combination. Duplicate claim number + claim suffix combinations will not be loaded into the MassHealth data warehouse.

2.3 Member IDs

Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

2.4 Provider IDs

MassHealth is asking MCEs to provide an identifier that is unique to the MCE. The acceptable ID types are:

ID Type	ID Description	Comments
1	NPI	Accepted for any provider including Referring and Prescribing Provider IDs. *Note*: MassHealth expects MCEs to submit MCE Internal ID in Provider IDs and use NPI as a Provider ID only when necessary and when an internal ID is not available. When NPI is used in Provider ID fields, provider file must have it entered in Field #2 (Provider ID) and in field #26 (NPI). Field #26 (NPI) must also be populated for all other Provider ID types except when it is not available, like in the case of atypical providers.
6	MCE Internal ID	Accepted for any provider
8	DEA Number	Should be used with pharmacy claims only
9	NABP Number	Should be used with pharmacy claims only

- The Provider ID, Provider ID Type, and Provider ID Address Location Code should be 100 % present on all provider records.
- 100% of Pharmacy and Physician-Administered Drugs claims must have Billing Provider NPI numbers in provider file
- At least 80% of all the records in the Provider file should have NPI numbers included, or the submission file will be rejected.
- At least 80% of all the records in the Provider file should have Provider Type included, or the submission file will be rejected.
- All the provider records in provider file, which are part of the PCC enrollment with MCE, need to have PCC details on the same line.

2.5 NPI

The Centers for Medicare & Medicaid Services (CMS) require all Medicare and Medicaid providers and suppliers of medical services that qualify for a National Provider Identifier (NPI) to include NPI on all claims. Type 1 NPI is for Health care providers who are individuals, including physicians, psychiatrists, and all sole proprietors. Type 2 NPI is for Health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

MCEs should submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing, and Primary Care Providers in Provider file. MCEs should submit individual (Type 1) or group (Type 2) NPI for billing providers and PCCs.

MH DW will closely monitor submission of servicing/rendering, billing, and referring provider NPI numbers in Provider File. With a change of the business rules, claims with missing NPI numbers in Provider File might be rejected. MCEs will be notified about the change ahead of time.

The above does not apply to “atypical” providers.

2.6 DRG

The DRG field (field #72) is a field requested by CMS. Not all MCEs collect DRGs, so MassHealth has developed a preferred course of action:

1. An MCE that collects DRGs- should provide DRG values in data submissions.
2. An MCE that does not collect DRGs, should ensure that primary, secondary, and tertiary diagnosis values are as complete and accurate as possible, so that MassHealth may use a DRG grouper if necessary. Accurate procedure codes are also required for DRG assignment.
3. In the future, MassHealth may request that all MCEs provide DRGs.
4. MassHealth requests from MCEs that report DRGs to also report in DRG related fields: DRG Type, DRG Version, Severity of Illness level, and Risk of Mortality.

2.7 Diagnosis Codes

The values in all Diagnosis fields listed in Data Elements section should be submitted when available. Submit on Dental claims when available.

Requirements for validity and completeness are detailed in the ICD clinical guide published by the American Medical Association. Current validating process at MH DW requires:

- at least one diagnosis code (in Primary Diagnosis field #19) for all applicable encounter types as specified in section 8.0.
- diagnosis codes contain the required number of digits outlined in the ICD code books.
- code to the seventh digit when applicable (blank filled when less than seven digits are applicable). DO NOT include decimal points in the code. For example, S72.111A must be entered as S72111A.
- Diagnosis Code must be consistent with ICD Version Qualifier.

Other Guidance:

- On Transportation claims for the services like “a ride to the grocery store”, MCEs should use generic diagnosis codes such as:
  - Z993 – Dependence on wheelchair
  - Z87898 – Personal history of other specified conditions

2.8 Procedure Codes

Many MCEs accept and use non-standard codes such as State specific and MCE specific codes. Current validating process at EHS DW looks for standard codes only - CPT, HCPCS, and ADA.

HIPPAA regulations require that only standard HCPCS Level I (CPT) and II be used for reporting and data exchange. The only field containing HCPCS Level I and II procedure codes is the Procedure Code field (#26). ICD-10 PCS procedure codes should be populated in the Surgical Procedure Code fields (103-111, 206-221).

2.9 Capitation Payments

Capitation payment arrangement refers to a periodic payment per member, paid in advance to health care providers for the delivery of covered services to each enrolled member assigned to them. The same amount is paid for each period regardless of whether the member receives the services during that period or not.

Note: Capitation payment is not "Bundled" payment, which is usually paid for Episodes of care or other bundled services.

2.10 Dollar Amounts

MassHealth wants to ensure that the dollar amounts on the individual lines of the claim represent the actual or computed amounts associated with each encounter. Therefore, whenever dollar amounts are not included at the detail level, and the summary-level line is not available, the MCE should add an extra detail line with a Record Indicator of 0 and report all summary-level amounts/quantities on that line. If the summary-level line is already available in the MCE's source system and is not artificially created, then MassHealth would expect it to have a Record Indicator value of 4 (Per diem), 5 (DRG) or 6 (Bundled Summary-Level line when none of the other payment arrangements apply).

All detail lines with zero-dollar amounts (that are not artificially created and are not summary-level lines) should have any value other than 0 or 6 placed in Record Indicator field. In such case, MCE decides on the value based on the definition of the Record Indicator in the table below.

For the claims covered by sub-capitation payments and are zero paid in the source system, MCEs would report a Fee-For-Service Equivalent (FFSE) in the Net Payment field (#68) and use Record Indicator value 2 or 8 depending on the type of capitated service. See "Acronyms" section for MassHealth's expectation for an FFSE.

Record Indicator Table:

Record Indicator	Dollar Amount Split
0: Artificial Line	Dollar amounts / quantities represent numbers that are available only at a summary level.
1: Fee-For-Service	Dollar amounts should be available at the detail line level in the source system. Primary Care Sub-Capitation services for ACPPs services must be reported using Record Indicator of 8 or 9 for dates of service on or after 4/1/23.
2: Encounter Record with Fee-For-Service-Equivalent (FFSE)	Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system. Primary Care Sub-Capitation services for ACPPs must be reported using Record Indicator 8 or 9 for dates of services on or after 4/1/23.
3: Encounter Record w/out FFS equivalent	DECOMMISSIONED
4: Per Diem Payment	Use for Per Diem payment arrangements. One line would have the total dollar amount for the day or stay.
5: DRG Payment	Use for DRG payment arrangements. One line would have the total dollar amount for the entire stay.
6: Bundled Summary-Level Line	Total dollar amount for a bundled summary-level claim line where the dollar amounts represent numbers that are available only at a summary line level in the source system and is not artificially created. A record with indicator = 6 for a summary-level line of a bundled claim is used when none of the above payment arrangements apply.
7: Bundled detail line with 0-dollar amount	A bundled detail claim line where the dollar amounts are 0 or not available at the detail level. A record with indicator = 7 is used for a detail-level line of a bundled claim when none of the above payment arrangements apply.
8: Primary Care Sub-Capitation Payment	Net Payment is zero because the provider is compensated with a Primary Care Sub-Capitation payment for this service. Effective for claims with dates of service on or after 4/1/23.
9: Primary Care Sub-Capitation FFS Exemption	MassHealth would consider this service as part of the Primary Care Sub-Capitation; however, the plan is compensating the provider on an FFS basis for this

Record Indicator	Dollar Amount Split
	service. Effective for claims with dates of service on or after 4/1/23.

Examples of possible scenarios for Record Indicator values

Example 1 – Artificial Line 0 and Detail Lines with Record Indicator 4

Claim Number	Claim Suffix	Record Indicator	Revenue Code	Payment Amount
12345678911	1	4- Per Diem Payment	0112	0
12345678911	2	4- Per Diem Payment	0300	0
12345678911	3	4- Per Diem Payment	0250	0
12345678911	4	4- Per Diem Payment	0720	0
12345678911	5	0 -Artificial Line: dollar amounts available at summary level only	NULL	10000

Example 2 – Per Diem payment on one claim line with Room and Board Revenue Code:

Claim Number	Claim Suffix	Record Indicator	Revenue Code	Payment Amount
12345678911	1	4- Per Diem Payment	0410	0
12345678911	2	4- Per Diem Payment	0300	0
12345678911	3	4- Per Diem Payment	0250	0
12345678911	4	4- Per Diem Payment	0123	10000

Example 3 – Artificial Line and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
12345678911	1	7 – Bundled detail line with $0 amount	0
12345678911	2	7 – Bundled detail line with $0 amount	0
12345678911	3	0 – Artificial Line: dollar amounts available at summary level only	100

Example 4 – Bundled Summary Line 6 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
12345678911	1	7 – Bundled detail line with $0 amount	0
12345678911	2	7 – Bundled detail line with $0 amount	0
12345678911	3	6 – Bundled Summary-Level line	500

Example 5 – FFS/E Record Indicator Values Use Scenarios:

#	Scenario	If Primary Care Sub-Capitation Included Service	Net Payment (field #68)	Record Indicator (field #4)
1	Provider is paid a Primary Care Sub-Capitation for the service.	Yes	$0	8: Primary Care Sub-Cap Payment
2	Provider is paid FFS for a Primary Care Sub-Capitation service. *	Yes	>$0	9: Primary Care Sub-Cap FFS Exemption
3	Plan considers service to be primary care; however, it is not in scope for the Primary Care Sub-Capitation program. Plan capitates provider for this service.	No	>$0 FFSE	2: Encounter Record with FFSE
4	Service is not a primary care service and provider is paid FFS. Net payment is the plan's claims system paid amount (may be zero in certain instances like bundling/DRG/per diem).	No	>=$0	1: Fee-For-Service
5	Service is not a primary care service and provider is paid zero for the service (e.g., specialty provider is capitated).	No	>$0 FFSE	2: Encounter Record with FFSE

2.11 Claim Number & Suffix

Every Original / Void or Replacement claim submitted to MassHealth should have a new claim number + suffix combination. There can be no duplicate claim number + claim suffix in one feed

2.12 Former Claim Number & Suffix

In order to void or replace old transactions, MassHealth requires for all the MCEs to add former claim number and former claim suffix to the claim lines of record type 'R', 'V'. The objective is to get a snapshot of the claims at the end of each period after all debit or credit transactions have been applied to them.

When there are duplicate services submitted on multiple claim records with different claim number + suffix combinations, MassHealth will consider the record with the latest paid date as the active claim line.

Examples:
Replacements

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date
XXX	11111111111	4	1	O			10	7/15/20
XXX	33333333333	4	1	R	11111111111	4	20	8/1/20
XXX	88888888888	4	1	R	33333333333	4	25	9/1/20

Voids

Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date	Void Reason Code (#118)
66666666666	1	1	O			15	1/5/2020	
77777777777	2	1	V	66666666666	1	0	3/1/2020	3 (provider audit recovery)

2.13 Record Creation Date

This is the date on which the claim was created in the MCE's database. If a replacement record represents the final result of multiple adjustments to a claim between submissions, Record Creation Date is the date of the last adjustment to that claim. For encounter records where Record Indicator value is 2 or 3, Record Creation Date should be the same as the Paid Date.

2.14 MassHealth Inpatient vs. Outpatient Claim Determinations

Old, pre-November 2016, DW Logic

MassHealth applies a modified logic on encounter data to identify "Inpatient" claims. This new logic is an internal change that does not affect the encounter data submission process and only applies to the claims with "From Service Date" (field# 17) on or after October 1, 2016.

New DW Logic

Claims with Claim Category = 1 (Facility except LTC) and **Type of Bill** values **11x and 41x** are defined as "Inpatient". All other claims with Claim category = 1 are defined as "Outpatient".

2.15 LTC Claims

Claims with Claim Category = 6 (Long Term Care - Nursing Home, Chronic Care & Rehab) are defined as **"LTC"**. MCEs should ***continue*** sending all "Long Term Care" claims with Claim Category='6'.

2.16 Physician-Administered Drug Claim Definition

Claims with Claim Category 1 (Facility except LTC) or 2 (Professional) and value in "NDC Number" field (#37).

2.17 Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net (" (#68). MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing and should work with their PBM or other vendors to separate out the administrative fees from the encounter cost component in their claim processing.

2.18 Bundle Indicator, Claim Number & Suffix

The Bundle indicator is a Y/N field to indicate that the claim line is part of a bundle. This indicator should always be 'Y' for **all** bundled claims (see example 1 and 2). The Bundle Claim Number and Suffix refer to the claim number and the claim suffix of the claim line with the bundled payment. The examples below illustrate how these two fields should be populated. Example 1 illustrates a scenario with one bundle within a claim, Example 2 illustrates a scenario with multiple bundles within a claim, and Example 3 illustrates a scenario with one bundle across multiple claims.

The assumption is that when a bundled claim line gets adjusted, all bundled claim lines for that claim would be adjusted as well. Please see Examples 4 and 5 below for scenarios where there is a Replacement or Void of a bundled claim. MCE should leave the Bundle claim number and suffix blank when this assumption is inaccurate and when they do not have this information. However, these two fields are expected when MCE have this information in their system. Bundle Indicator should be provided on all bundled claims with no exception.

Example 1 – One Bundle per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	AAAAAAAA	1	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	2	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	3	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	4	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	5	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	6	Y	AAAAAAAA	6	120

Example 2 – Two Bundles per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	CCCCCCCC	1	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	2	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	3	Y	CCCCCCCC	3	60
XXX	CCCCCCCC	4	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	5	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	6	Y	CCCCCCCC	6	80

Example 3 – One Bundle for Two Claim Numbers:

Claim Payer	Claim Number	Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	DDDDDDDD	1	NNNNNNNN	1	0
XXX	DDDDDDDD	2	NNNNNNNN	1	0
XXX	DDDDDDDD	3	NNNNNNNN	1	0
XXX	NNNNNNNN	1	NNNNNNNN	1	50

Example 4 – Replacement/Void of Bundled Claims with Record Indicator 0:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	44444444444	1	O			44444444444	4	0	4	96360
XXX	44444444444	2	O			44444444444	4	0	4	96375
XXX	44444444444	3	O			44444444444	4	0	4	96376
XXX	44444444444	4	O			44444444444	4	260	0	
XXX	55555555555	1	R	44444444444	1	55555555555	4	0	4	96360
XXX	55555555555	2	V	44444444444	2	55555555555	4	0	4	96375
XXX	55555555555	3	R	44444444444	3	55555555555	4	0	4	96376
XXX	55555555555	4	R	44444444444	4	55555555555	4	200	0	

Example 5 – Replacement/Void of Bundled Claims with Record Indicator 6:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	3EA11
XXX	66666666666	2	O			66666666666	3	500	6	G0299
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	3EA11
XXX	77777777777	2	R	66666666666	3	77777777777	3	400	6	G029

2.19 Submission Clarification Code

The Submission Clarification Code (#13, 229, and 230) is populated with a 420-DK-Code when the pharmacist is clarifying the submission. MassHealth requires that a Submission Clarification Code value of 20 be included on the claim when the pharmacy has determined the product being billed is purchased pursuant to right available under Section 340B of the Public Health Act of 1992 including sub-celling purchases authorized by section 340B(a)(10) and those made though the Prime Vendor Program 340B(a)(8).

For additional information about submission clarification code values, please refer to the NCPDP standards. For additional information about submission clarification code values, please refer to the NCPDP standards.

2.20 Provider ID Submission in Encounter and Provider Files

Among several elements introduced in Version 4.6 of these specifications were Provider ID Address Location Code fields.

The values in the “Provider ID”, “Provider ID Type”, and “Provider ID Address Location” fields entered in claims file should match the values in corresponding fields of the provider file.

Consistent with MassHealth policy for implementing 42 CFR 438.602(b)(1), plans are asked to store the MassHealth Provider Identification number (PIDSL) information that is provided by MassHealth in their systems and provide that information when submitting their ongoing file exchanges as directed by MassHealth, as well as in the event of an audit. When submitting encounter files, MCEs are required to report the MassHealth PIDSL in the “Medicaid Number” field for each provider in their Provider File (field #5).

Example: Claims File

Entity PIDSL	Claim Number	Claim Suffix	Servicing Provider ID	Servicing Provider ID Type	Servicing Provider ID Address Location Code
999999999R	98765432WS	1	1234569	6	A
999999999R	23568974RV	1	1234568	6	B
999999999R	741852969K	1	1234567	6	C
999999999R	369874123L	1	1234566	6	D

Example: Provider File

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234569	6	04	12345	Smith
999999999R	1234568	6	03	12345	Smith
999999999R	1234567	6	02	12345	Smith
999999999R	1234566	6	01	12345	Smith

2.21 Medicare Related Data

For SCO and OneCare plans, Medicare Code (#11) and Medicare Amount (#63) must be populated accurately and consistently per CMS requirements.

2.22 Programs with withhold amount

Some Managed Care programs include withhold risk-sharing arrangements with their providers when a portion of the approved payment amount is withheld from the provider payment amount and placed in a risk-sharing pool for later

distribution. In such case, the withheld amount should be recorded in a separate field “Withhold Amount” (#69) and included in Allowable Amount (#86).

2.23 Recoveries

All claim lines with a payment recovery or other adjustment to the original claim line related to TPL, accident recovery, or provider audit recoveries must have the Void Reason Code populated (#118), including for all Voids and Replacements. Voids and/or Replacements for provider audit recoveries should include all overpayments recovered or otherwise adjusted as a result of program integrity fraud, waste, and abuse controls, including but not limited to provider audits, surveillance and utilization reviews, investigations, post-payment claims edits, algorithms, and provider self-disclosures.

3.0 Encounter Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the encounter record. It is divided into five sub-sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For the fields that contain codified values (e.g., Patient Status), we use national standard (e.g., UB92 coding standards) values whenever possible.

In the table below "X" indicates a Claim Category the data element is applicable in. The columns are labeled as:

- H – Facility (except Long Term Care)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization (MCE). **This code identifies your organization** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 Health New England 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 999 Massachusetts Behavioral Health Partnership 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care)	X	X	X	X	X	3	N
2	Claim Category	Assign claim category based on claim source (e.g., 837i, 837p, 837d). Valid values are:	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		1 = Facility (except Long Term Care) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care (Nursing Home, Chronic Care & Rehab) Facility encounters with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to LTC (Claim Category = 6) with the remainder to Facility/not LTC (Claim Category = 1). *Note*: Section 2.0 Data Element Clarifications explains how MassHealth uses the MCE assigned Claim Category together with Type of Bill to determine Inpatient vs. Outpatient facility.							
3	Entity PIDSL (Provider ID Service Location	ACO PIDSL on the ACO claims (An ACO with which a PCC is contracted with) or MCO PIDSL on the MCO claims or One Care Plan PIDSL on One Care claims or SCO PIDSL for SCO claims Example: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid as reported in Net Payment #68. 0 - Artificial line – Dollar amounts / quantities represent numbers that are available only at a summary level. 1 - Fee for Service - Dollar amounts should be available at the detail line level in the source system. Primary Care Sub-Capitation services for ACPPs must be reported using Record Indicator 8 or 9 for dates of services on or after 4/1/23**.** 2 - Encounter Record with Fee-For-Service-Equivalent (FFSE) - Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system. Primary Care Sub-Capitation services for ACPPs must be reported using Record Indicator 8 or 9 for dates of services on or after 4/1/23**.** 3 - DECOMMISSIONED 4 - Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 - DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis. 6 - Bundled Summary-Level Line – Refers to a record with bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. 7 - Bundled detail line with 0-dollar amount - Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply.	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		8 - Primary Care Sub-Capitation Payment - Net Payment is zero because the provider is compensated with a Primary Care Sub-Capitation payment for this service. Effective for claims with dates of service on or after 4/1/23. 9 - Primary Care Sub-Capitation FFS Exemption - MassHealth would consider this service as part of the Primary Care Sub-Capitation; however, the plan is compensating the provider on an FFS basis for this service. Effective for claims with dates of service on or after 4/1/23. See discussion under Dollar Amounts in the Data Elements Clarification Section for additional instruction.							
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. See discussion under Claim Number/Suffix in the Data Elements Clarification section.	X	X	X	X	X	25	C
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. See discussion under Claim Number/Suffix in the Data Elements Clarification section.	X	X	X	X	X	4	C
7	Pricing Indicator	Placeholder for Pricing Indicator. MCEs will be notified if implemented.						20	C
8	Recipient DOB	The birth date of the patient expressed as **YYYYMMDD**. For example, August 31, 1954, would be coded "19540831."	X	X	X	X	X	8	D/YYYY MMDD
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female 3 = Other	X	X	X	X	X	1	C
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X	5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. Medicare code should indicate what part of Medicare is being used to cover the services billed within the claim, NOT all of the parts of Medicare that the member is enrolled in. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B 4 = Part D Only	X	X	X	X	X	1	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		5 = Part A and D 6 = Part B and D 7 = Part A, B, and D							

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether or not third-party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. 420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment *2.0 Data Element Clarifications* for further information.				X		7	N
14	Claim Type	MBHP Specific field.	X	X	X		X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X			8	D/YYYYMMDD
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. The date cannot be prior to Admission Date.	X		X			8	D/YYYYMMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. See discussion about Diagnosis Codes, including decimal requirements, in ***Data Element Clarifications*** section. *Note:* Primary diagnosis and co-morbidities are for services rendered and thus may not match Admitting Diagnosis. For institutional claims, this would be the Principal Diagnosis Code on Admission from the UB04/837i.	X	X	X		X	7	C/ No decimal points
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See discussion about Diagnosis Codes in ***Data Element Clarifications*** section, including decimal requirements.	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See ***Secondary Diagnosis*** format in the row this one. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long-Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long-Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. Any internal coding systems used must be translated to one of the coding systems identified in field #30 below. Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#103 – #111, 206-221) ***including the ICD-treatment procedure codes*** See discussion in Data Element Clarifications section.	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in Surgical Procedure code fields (Field # 103 – 111, 206-221). State defined procedure codes should be used, when coded, for services such as EPSDT procedures. See discussion in the Data Element Clarifications section.	X	X	X		X	1	N
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. Only standard UB92 Revenue Codes values are allowed; plans may not use “in house” codes. Values should be sent in 4-digit format. Revenue codes less than 4-digits long should be submitted with leading zeros. For Example : Revenue code -1 - as ‘0001’ ; Revenue Code 23 - as ‘0023’ ; Revenue code 100 - as ‘0100’ ; Revenue Code 2100 – as ‘2100’.	X		X			4	C
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim).		X			X	2	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See Table C for CMS 1500 standard							
33	Type Of Bill	For encounter data supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services, and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. *Note:* for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K and are documented in field # 91 as well.	X		X			3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. Examples: Patient Discharge Status '1' should be submitted as '01'. Patient Discharge Status '19' should be submitted as '19'.	X		X			2	C
35	Filler							2	C
36	Quantity	This value represents the quantity billed and should be submitted with a decimal point when applicable. For most inpatient services billed at a per diem rate, MH expects the quantity to reflect the patient days a service was rendered, as governed by the midnight census. Count the day of admission, but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For procedures, MH expect the number of units performed. Please make sure that the Quantity corresponds to the procedure code. For example, if psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes) the Quantity should be "1" for this service, not "45" or "50" For anesthesia services, MH expects the total duration in minutes of anesthesia services administered. *Note*: The length of this field was increased to prevent rounding and to accommodate the unaltered quantity. Quantity = 10 should be submitted as 10. Quantity = 10.55 should be submitted as 10.55	X	X	X		X	9	N
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, if primary drug is unknown, submit NDC Number for most expensive drug. NDC codes should not be blank on pharmacy and Physician Administered Drug claims, including for compound drugs.	X	X		X		11	N
38	Metric Quantity	For prescription and physician administered drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Plans may need to derive the Metric Quantity for physician administered drugs using	X	X		X		9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		the procedure code and billed units. Unit of Measure #231 also needs to be populated to indicate the specific type of units counted here (e.g., each tablet, milligrams). *Note:* Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55							
39	Day Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2-digit format with leading zero: 00=No product Selection Available 01=Substitution Not Allowed by Prescriber 02=Substitution Allowed-Patient Requested Product Dispensed 03=Substitution Allowed-Pharmacist Selected Product Dispensed 04=Substitution Allowed-Generic Drug Not in Stock 05=Substitution Allowed-Brand Drug Dispensed as a Generic 06=Override 07=Substitution Not Allowed-Brand Drug Mandated by Law 08=Substitution Allowed-Generic Drug Not Available in Marketplace 09=Substitution Allowed by Prescriber but Plan Requests Brand				X		2	N
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X	2	C
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as “MOL “(three spaces following the third value).					X	6	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
45	Paid Date	For encounter records, the date on which the record was adjudicated (i.e., MCE system generated transaction date).	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	MBHP Specific field	X	X	X		X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section***.	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, 6 = Internal ID (Plan Specific)	X	X	X		X	1	N
49	PCC Provider ID	The Provider ID of the Practice the PCP is associated with. Plan's internal provider ID or NPI for the practice.	X	X	X		X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section***.	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 9 = NAPB Number (for pharmacy claims only)	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section***.	X	X	X		X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number (for pharmacy claims only)	X	X	X		X	1	N
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non-PCP 3 = Out of plan provider *Note:* This code relates to the class of the provider and a PCP does not necessarily indicate the recipient's selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X		X	1	C
55	Servicing Provider Type	A custom MassHealth code indicating the type of provider rendering the service represented by this encounter or claim. See Table G for values.	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider as reported on professional claims. Use CMS 1500/837p standard; see Table H. Optional for facility claims.		X			X	3	C
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	MBHP Specific field	X	X	X		X	25	C

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line-item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service or usual and customary for retail pharmacy if amount provider billed is not available.	X	X	X	X	X	9	N
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *Note*: Do not include Fee For Service equivalents; however, this field should include any withhold amount, if applicable. For pharmacy, the amount is what the plan pays the PBM for the drug: ingredient costs + dispensing fee + any other fees.	X	X	X	X	X	9	N
62	TPL Amount	Any amount of third-party liability paid by another medical coverage carrier for this service. If this is a recovery, such as an Accident Recovery, the appropriate Void Reason (#118) must also be provided. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X	9	N
63	Medicare Amount	Any amount paid by Medicare for this service. Must be consistent with Medicare covered services.	X	X	X	X	X	9	N
64	Copay	Any copayment amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field "Patient Pay Amount". Medicare copays should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
65	Deductible	Any deductible amount the member paid for this service. Medicare deductibles should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	N
67	Dispensing Fee	The dispensing fee pharmacy charged for filling the prescription. Should correspond to the NDCDP standard field: 507-F7				X		9	N
68	Net Payment	The amount the Medicaid MCE paid for this service and/or FFSE for the cost that the MCE incurred. MassHealth expects that it would generally equal Allowable Amount (#86) less TPL Amount (#62), Medicare Amount (#63), Copay (#64), Coinsurance (#117), Deductible (#65), Patient Pay Amount (#124) and Withhold Amount (#69). See Section 2.0 for more information about use of Record Indicator to indicate the payment arrangement under which the rendering provider was paid. For Pharmacy charges, the amount the Plan paid the PBM.	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives. See Section 2.0 for more information about Withholds.	X	X	X		X	9	N
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion in Data Elements Clarification section, "Record Type Submission Options and Explanations"***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C	X	X	X	X	X	25	C

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3- digit format. One and two-digit codes should be completed with leading zeros to comply. For example: DRG code '1' should be submitted as '001'. DRG code '25' should be submitted as '025'. DRG code '301' should be submitted as '301'. See discussion in the Data Element Clarifications section.	X		X			3	C
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral		X			X	1	N
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (See Table I)	X	X				1	C
75	MSS/IS	Please leave this field blank, it will be further defined at a later date. A flag that indicates services related to MSS/IS: 1 = Maternal Support Services 2 = Infant Support Services		X				1	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
76	New Member ID	The “active” MassHealth assigned Medicaid identification number for the enrollee that received the services. This number is assigned by MassHealth and is subject to change.	X	X	X	X	X	25	C

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
77	Former Claim Number	If this is not an original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. See discussion under ***Former Claim Number / Suffix*** in the Data Elements Clarification Section	X	X	X	X	X	25	C
78	Former Claim Suffix	If this is not an original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. See discussion under ***Former Claim Number / Suffix*** in the Data Elements Clarification Section	X	X	X	X	X	4	C
79	Record Creation Date	The date on which the record was created. See discussion under ***Record Creation Date*** in the Data Elements Clarification Section.	X	X	X	X	X	8	D
80	Service Category	Service groupings from financial reports like 4B (see Table I). See report instructions for definitions. Generally, * Assign Service category based on claim source (e.g., 837i, 837p, 837d). * Facility Claims with Type of Bill values 11x and 41x are defined as "Inpatient". Other facility claims would be "Outpatient". * Facility claims with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to Institutional Long Term.	X	X	X	X	X	5	C
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X		15	C
82	Date Script Written	Date prescribing provider issued the prescription.				X		8	D/YYYYMMDD
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No *Note* that this is not consistent with NCPDP.				X		1	C
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X		1	C
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. See discussion in Data Element Clarifications section, including clarification on ICD-10	X		X			7	C/No decimal points
86	Allowable Amount	The maximum amount the plan will pay for the service, which is generally the Plan Allowable Fee Schedule. For retail drugs, it is the amount allowed in formulary. Amount reported would equal plan payment + member responsibility.	X	X	X	X	X	9	N
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID or UPIN or other State assigned provider ID.	X					15	C
88	Non-covered Days	Days not covered by Health Plan.	X		X			3	N
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD V, W, X, Y-Code) present on the claim, it should be submitted in this field.	X		X			7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.							
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYYMMDD
91	Frequency	The third digit of the UB92 Bill Classification field. Submitted as a third digit in Type of Bill (#33)	X		X			1	C
92	PCC Provider ID_Type	One code identifying the type of ID provided in the PCC Provider ID in Field # 49 above. For example, 6 = Internal ID (Plan Specific) 8 = DEA Number 9 = NABP Number 1 = NPI	X	X	X		X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, 6 = Internal ID (Plan Specific) 9 = NABP Number (for pharmacy claims only)	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, 6 = Internal ID (Plan Specific)	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field must be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field must be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
101	Diagnosis 9	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
102	Diagnosis 10	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
104	Surgical Procedure code 2	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
105	Surgical Procedure code 3	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
106	Surgical Procedure code 4	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
107	Surgical Procedure code 5	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
108	Surgical Procedure code 6	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
109	Surgical Procedure code 7	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
110	Surgical Procedure code 8	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
111	Surgical Procedure code 9	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
112	Employment	Is the patient's condition related to Employment? Y N	X	X	X		X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident? Y N	X	X	X		X	1	C
114	Other Accident	Is the patient's condition related to Other Accident? Y N	X	X	X		X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period. For pharmacy claims, may be same amount as Gross Payment Amount (#61) for pharmacy claims if there is no separate charge for uncovered services or copay.	X	X	X	X	X	9	N
116	Non-Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary payer for this service.	X	X	X		X	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field “Patient Pay Amount”. Medicare coinsurance should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided. 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other Must be provided on the record for all adjustments to the original claim line related to TPL, accident recovery, or provider audit recoveries, including all Voids and Replacements. Recoveries are expected to have a value 1-3. TPL recoveries must also be reflected in TPL Amount field (#62). 4-Other should only be used when 1-3 are not appropriate.	X	X	X	X	X	1	C
119	DRG Description	Description of DRG Code	X		X			132	C
120	DRG Type	Values: 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other Please use the accurate and specific DRG type and avoid using the value “Other”. Please communicate to MassHealth any DRG types you are using that are missing from the above list.	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (S72.111A as S72111A)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG. With the exception of DRG 589, valid values are: 1 = minor	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		2 = moderate 3 = major 4 = extreme Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields							
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. With the exception of DRG 589, valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays.	X		X			9	N
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
128	Present on Admission (POA) 1	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
129	Present on Admission (POA) 2	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
132	Present on Admission (POA) 5	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
133	Present on Admission (POA) 6	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
134	Present on Admission (POA) 7	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
135	Present on Admission (POA) 8	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
136	Present on Admission (POA) 9	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
137	Present on Admission (POA) 10	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
138	Diagnosis 11	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
139	Present on Admission (POA) 11	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
140	Diagnosis 12	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
141	Present on Admission (POA) 12	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
142	Diagnosis 13	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
143	Present on Admission (POA) 13	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
144	Diagnosis 14	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
145	Present on Admission (POA) 14	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
146	Diagnosis 15	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
147	Present on Admission (POA) 15	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
148	Diagnosis 16	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
149	Present on Admission (POA) 16	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
150	Diagnosis 17	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
151	Present on Admission (POA) 17	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
153	Present on Admission (POA) 18	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
155	Present on Admission (POA) 19	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
156	Diagnosis 20	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
157	Present on Admission (POA) 20	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
159	Present on Admission (POA) 21	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
160	Diagnosis 22	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
161	Present on Admission (POA) 22	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
162	Diagnosis 23	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
163	Present on Admission (POA) 23	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
164	Diagnosis 24	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
165	Present on Admission (POA) 24	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
166	Diagnosis 25	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
167	Present on Admission (POA) 25	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
168	Diagnosis 26	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
169	Present on Admission (POA) 26	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
170	Present on Admission (POA) EI 1	This is an indicator associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
172	Present on Admission (POA) EI 2	This is an indicator associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD- V, W, X, Y- Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
174	Present on Admission (POA) EI 3	This is an indicator associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
176	Present on Admission (POA) EI 4	This is an indicator associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
178	Present on Admission (POA) EI 5	This is an indicator associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
180	Present on Admission (POA) EI 6	This is an indicator associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
182	Present on Admission (POA) EI 7	This is an indicator associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
184	Present on Admission (POA) EI 8	This is an indicator associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
186	Present on Admission (POA) EI 9	This is an indicator associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
188	Present on Admission (POA) EI 10	This is an indicator associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
190	Present on Admission (POA) EI 11	This is an indicator associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD- V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
192	Present on Admission (POA) EI 12	This is an indicator associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
193	ICD Version Qualifier	ICD9 or ICD10. The value “ICD9” must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value “ICD10” must be populated on claim records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must never have a combination of ICD9 and ICD10 codes. See discussion in Data Element Clarifications section, including clarification on ICD-10	X	X	X		X	5	C
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X	2	C
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: ‘4B’ for MCO Service Categories ‘ACO’ for ACO Categories ‘SCO’ for SCO Service Categories ‘ICO’ for Care One (ICO) Service Categories	X	X	X	X	X	3	C
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY TRANSPORTATION SERVICES.		X				3	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X				5	N
198	Prescription Number	Rx Number.				X		15	C
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X	10	C
200	Rate Increase Indicator	**DEPRECATED AFTER 2014** Indicates if the provider is eligible to receive the enhanced primary care rate for this service, as specified in the Affordable Care Act – Section 1202 final regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable *Note*: If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.	X	X	X			1	C
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.	X	X	X		X	1	C
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. See discussion in Data Element Clarifications section,	X	X	X		X	15	C
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. See discussion in Data Element Clarifications section,	X	X	X		X	4	C
204	Value Code	Code used to relate values to identify data elements necessary to process a UB92 claim. Submit only when the value=54 for Newborn claims	X					2	AN
205	Value Amount	Weight of a newborn in grams. Must be present on all newborn claims when the value code "54"is submitted in Field #204	X					9	N
206	Surgical Procedure Code 10	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
207	Surgical Procedure Code 11	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
208	Surgical Procedure Code 12	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank.	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
209	Surgical Procedure Code 13	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
210	Surgical Procedure Code 14	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
211	Surgical Procedure Code 15	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
212	Surgical Procedure Code 16	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
213	Surgical Procedure Code 17	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
214	Surgical Procedure Code 18	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
215	Surgical Procedure Code 19	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
216	Surgical Procedure Code 20	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
217	Surgical Procedure Code 21	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
218	Surgical Procedure Code 22	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
219	Surgical Procedure Code 23	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
220	Surgical Procedure Code 24	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank.	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
221	Surgical Procedure Code 25	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID in field #87	X					15	C
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID in field # 58	X	X	X	X	X	15	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID in field # 81				X		15	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X		X	15	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			15	C
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID in field # 50	X	X	X	X	X	15	C
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID In field # 49	X	X	X		X	15	C
229	Submission Clarification Code 2	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
230	Submission Clarification Code 3	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
231	Unit of Measure	To be provided on all Pharmacy and Physician-Administered Drugs claims. The unit of measure for the value entered in “Metric Quantity” field (# 38), e.g., grams, milliliters. Observe industry standard specific to each drug (e.g., HEDIS measure requirements). Please refer to Table O for the allowed values, standard references, and available links.	X	X		X		2	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
232	Provider Payment	The Gross Amount that the Plan/PBM paid to the pharmacy for the claim. Exclude any amounts paid to the PBM that were not passed on to the pharmacy.				X		9	N
233	Filler							9	N

* Key to Data Types

C - Character

- Includes space, A-Z (upper or lower case), 0-9
- Left justified with trailing blanks.
- Unrecorded or missing values are blank

N - Numeric

- Include 0-9.
- Right justified, lead-zero filled.
- Unrecorded or missing values are blank

D - Date Fields

- Dates should be in a numeric format.
- The format for all dates is eight digits in YYYYMMDD format, where YYYY represents a four-digit year, MM = numeric month indicator (01 - 12); DD = numeric day indicator (01 - 31).

Example: November 22, 1963 = 19631122

Financial Fields

MassHealth prefers to receive both dollars and cents, with an **implied decimal point** before the last two digits in the data.

Example: data string “1234567” would represent $12,345.67

3.1 Provider File Data Set with Record Layout

Data Elements

- This section describes the provider file to be submitted along with each encounter data submission. The file includes a complete snapshot of current provider data at the provider/location level of detail.
- The effective date and termination (“term”) date fields provide a history of changes to provider status. The intervals described by these dates should not overlap. All effective date and term date fields should have values. For records describing current status, use ‘99991231’ as the “End of Time” value.
- Provider ID, Provider ID Type and Provider ID Address Location Code values must match the values in corresponding fields in the encounter file.

- Each Provider service location **must** have its own identifier (see definition of the Provider ID Address Location Code below).

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization (MCE) **This code identifies your organization:** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a.-Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 Health New England 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 999 Massachusetts Behavioral Health Partnership 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care)	3	N
2	Provider ID	Multiple formats for the same Provider ID must be avoided. For example, ID '00001111' and '001111' should be submitted with one consistent format if it indicates the same ID for the same provider. Will be used to link back to the Provider ID on the claim.	15	C
3	Provider ID Type	A code identifying the type of ID provided in the Provider ID above. For example, 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NABP Number (For Pharmacy claims ONLY) Will be used to link back to the Provider ID Type on the claim.	1	C
4	License Number	State license number.	9	C
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider PIDSL). Plans should use information in their systems pursuant to CFR 438.602(b)(1) to populate this field. See Provider ID Submission segment in Section 2.0 for more information.	10	C
6	Provider Last Name	Last name of provider. In case of an organization or entity or hospital, name should be entered in this field only. Please avoid using abbreviations and enter names consistently. For example, enter "Massachusetts General Hospital" instead of "MGH". Length increased to 200 characters	200	C
7	Provider First Name	First name of the provider	100	C

#	Field Name	Definition/Description	Length	Data Type
		Please submit First Name consistently. In case of an organization or entity or hospital, name should be entered in "Provider Last Name" field above and **not** in this field. Length increased to 100 characters		
8	Provider Office Address Street	Street address where services were rendered. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
9	Provider Office Address City	City where services were rendered.	20	C
10	Provider Office Address State	State where services were rendered.	2	C
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4	9	C
12	Provider Mailing Address Street	Street address where correspondence is received. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
13	Provider Mailing Address City	City where correspondence is received.	20	C
14	Provider Mailing Address State	State where correspondence is received.	2	C
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4	9	C
16	Provider Type	Please use the values from Table G. *Note* that value "-4" for "Incomplete/No Information" option has been removed.	3	N
17	Filler		3	C
18	Provider Effective Date	Date provider becomes eligible to perform services.	8	D
19	Provider Term Date	Date provider is no longer eligible to perform services.	8	D
20	Provider Non-par Indicator	Non-participating provider indicator. 0 non-participating provider 1 participating provider	1	C
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).	15	C
22	PCC Provider ID	Required for PCCs enrolled with the MCE. Plan's internal provider ID or NPI for the practice.	15	C
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients	1	C
24	Provider DEA Number	Provider DEA Number	11	C
25	Provider Type Description	Description of the provider type	50	C

#	Field Name	Definition/Description	Length	Data Type
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required for all providers.	10	C
27	Medicare ID Number	Medicare ID Number	15	C
28	Social Security Number	Provider's SSN is 9 digits field and should be entered with no dashes (e.g.,04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
29	NABP Number	National Association of Boards of Pharmacy number	9	C
30	Tax ID Number	Tax ID Number is primarily the Federal Employee Identification Number (FEIN); however, when Providers do not have Tax ID Number for the reasons like being sole proprietors or small business owners without employees, provider's SSN should be entered in both fields, # 28 and #30, in same 9 digits format with no dashes (e.g.,04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
31	PCC Provider ID Type	A code identifying the type of ID provided in the PCC Provider ID above. 1 = NPI 6 = Internal ID (Plan Specific)	1	C
32	Gender Code	"M" for Male, "F" for Female, and "O" for Other	1	C
33	Primary Care Eligibility Indicator	Provider is eligible to receive enhanced Medicare rate for their primary care services. This indicator should follow the CMS and MassHealth regulations on provider eligibility for Affordable Care Act – Section 1202. 0=Yes, Eligible based on 60% Attestation 1=Yes, Eligible based on-Board Certification 2=No, Not Eligible 3=Unknown 4=Not Applicable *Note*: The values '0' and '1' indicating provider eligibility for the "ACA Section 1202" Rate Increase should be only applicable when providers have active contracts with MCEs. If a provider contract gets terminated then the provider would no longer be eligible for the rate increase, and the value for this flag would be '2' (Not Eligible). The assumption is that eligible providers are either eligible based on-Board Certification or 60% attestation. In the case where the MCE receives a 60% attestation from a provider that has already been determined to be eligible based on-Board Certification then MCE should use value "1".	1	C
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (Org ID) for the provider. Length is 6 characters. It should be submitted for all providers whose Org ID had been submitted to APCD.	6	C
35	Entity PIDSL	MCO/ACO providers - if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL - if the provider is enrolled with ACO only - ACO PIDSL - if the provider is enrolled with both, ACO and MCO, then ACO PIDSL - if provider is enrolled with multiple ACOs (e.g., a specialist), and a plan is an active MCO - MCO PIDSL	10	C

#	Field Name	Definition/Description	Length	Data Type
		- if provider is enrolled with multiple ACOs (e.g., a specialist) and a plan is not an active MCO - old MCO PIDSL SCO PIDSL for SCO providers One Care PIDSL for One Care providers Example: 999999999A		
36	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2. Will be used to link back to the Provider ID Address Location Code on the claim.	15	C
37	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID in Field # 22.	15	C
38	Provider Network ID Type	Type of Provider Network ID in Field # 21.	1	N
39	Provider Network ID Address Location Code	Code to identify address location of Provider Network ID in Field # 21.	15	C
40	Provider Bundle ID	ID to tie together all the IDs for a particular provider	15	C
41	Provider ID Primary Address Location Indicator	Y/N value to indicate primary address location	1	C

Example of Provider Bundle ID

This example shows the case when Provider ID is different for every location.

In most cases Provider ID is unique per each provider within the organization and will be the same on every line

Org. Code	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider ID Primary Address Location Indicator	Provider Last Name	Provider First Name
888	1234569	6	04	12345	N	Smith	John
888	1234568	6	03	12345	N	Smith	John
888	1234567	6	02	12345	Y	Smith	John
888	1234566	6	01	12345	N	Smith	John

Requirements for Acceptance of the Providers File

I. All records must contain values in these fields:

1. Org. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #3)
4. Provider Last Name (Field #6)
5. Provider First Name (Field #7)
6. Provider Office Address Street (Field #8)

7. Provider Office Address City (Field #9)
8. Provider Office Address State (Field #10)
9. Provider Office Address Zip (Field #11)
10. Provider Mailing Address Street (Field #12)
11. Provider Mailing Address City (Field #13)
12. Provider Mailing Address State (Field #14)
13. Provider Mailing Address zip (Field #15)
14. Provider Effective Date (Field #18)
15. Provider Term Date (Field #19)
16. Provider DEA Number when applicable (Field #24)
17. Provider ID Address Location Code (Field#36)
18. Provider Bundle ID (Field #40)
19. Entity PIDSL (Field# 35)
20. PCC Provider ID Type (#31) if PCC Provider ID is not null
21. PCC Provider ID Address Location Code (#37) if PCC Provider ID is not null

II. NPI must be present on at least 80% of the records.
III. Provider Type must be present on at least 80% of the records.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE. Records are currently not rejected if Medicaid Number/Provider PIDSL (field #5) or Tax ID Number (field #30) are missing values but are nevertheless very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

Provider File Records Validation Rules:

1. Provider records with null ID and/or null ID Type do not get loaded into MH DW. Such records get rejected and returned in the provider error response file.
2. If duplicate records per provider ID, Provider ID Type, Provider Address Location, and Provider Term Date are erroneously submitted, one record will be accepted based on “best fit” logic and all other records will be rejected and returned in the provider error file.
3. “Best” fit logic picks one record per provider ID, provider ID Type and provider Term Date in a provider file, based on the record that has the most populated information (NPI, provider name, address, tax ID, license number, and Medicaid Number, respectively).
4. Records sent with “null” or missing effective/term dates, will also be returned to the MCEs in the provider error response file.
5. All provider records rejected for any of the reasons above (except duplicate) should be corrected and included in a zipped correction submission.

3.2 MCE Internal Provider Type Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the provider type record that is based on the Provider Types that are internally used by the MCE. This is different from MassHealth Provider Types submitted in the Provider Data Set defined above. This table should only have providers who have an internal provider type code. In other words, this table should not have providers with missing internal provider type code.

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization (MCE) **This code identifies your organization:** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 Health New England 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 999 Massachusetts Behavioral Health Partnership 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care)	3	N
2	Provider ID	Provider ID.	15	C
3	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	N
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE	6	C
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE	120	C
6	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2	15	C

3.3 Provider Specialty Data Set Elements

Requirements for Acceptance of the Provider Specialties File

All records must include these fields:

1. Org. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #5)
4. Provider ID Address Location Code (Field #7)

Data Elements

This section contains field names and definitions for the provider specialty record. If a provider has multiple specialties, please provide one record for each specialty per provider.

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization (MCE) **This code identifies your organization:** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 Health New England 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 999 Massachusetts Behavioral Health Partnership 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care)	3	N
2	Provider ID	Provider ID, Federal Tax ID, UPIN or Health Plan ID.	15	C
3	Provider Specialty	Please use the values contained in Table H. If there are provider specialties not contained in table H, assign them a new three-digit number. List the description of the new values in the Provider Specialty Description field.	3	C
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.	8	D
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example: 1 = NPI	1	C

#	Field Name	Definition/Description	Length	Data Type
		6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number		
6	Provider Specialty Description	Description of the Provider Specialty	50	C
7	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	15	C

3.4 Additional Reference Data Set Elements (MBHP only)

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	ATHTYP	Two-digit code identifying the type of service.	6	C
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.	100	C

Claim Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	CLATYP	Code identifying a service.	6	C
3	CLATYP DESCRIPTION	Description for the CLATYP codes	100	C

Group Number Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	Member Rating Category	Description for the Member Rating Category.	50	C
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.	50	C
4	Eligibility Group Name	Description for the Eligibility Group Name.	100	C
5	Eligibility Group Number	Six-digit number identifying the Eligibility Group.	10	N

#	Field Name	Description	Length	Data Type
6	MMIS Plan Type	Two-digit code identifying the MMIS Eligibility Plan Type.	2	C

Service Class Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	Service Class	Code identifying a service class.	10	C
3	Description	Description of service class codes	100	C

Services Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization	3	N
2	SVCLVLE	Description of Service Level I.	60	C
3	SVCLVLMHSA	Description of Service Level II.	90	C
4	SVCGRP	Description of Service Level III.	100	C
5	SVCDESC	Description of Service Level IV.	120	C
6	UNITTYP	Description of Unit Type.	4	C
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.	12	N
8	ATHTYP	Authorization Type Code.	1	C
9	SVCCOD_REFSERVICES	Service Code.	6	C
10	CLATYP_REFSERVICES	Claim Type Code.	2	C
11	MOD1_REFSERVICES	Modifier Code.	2	C
12	ID_SERVICES	ID Services Value.	10	N
13	CBHI_FLAG	An indicator to distinguish CBHI Services	10	C
14	SERVICE_24_HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)	11	C

#	Field Name	Description	Length	Data Type
15	INTERMEDIATE_SVCLVLE	Specifies what kind of Intermediate Service Level was provided	50	C
16	SVCLVLI	Specifies service level provided	60	C
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA	2	C
18	SVCDIRECTORY	Service Directory	82	C

4.0 Encounter Record Layout Amendment Process and Layout

1. Amendment processing has been created to allow MCEs to make retroactive changes to the existing claims. “Existing” are the claims that have been accepted and loaded in MH DW.
2. MH DW expects that amendments are used to reflect retroactive dimension changes, such as Member ID, Servicing Category, etc.
3. There are no constraints on timing for submissions of the amendments.
4. Amendments can be sent as a part of a regular submission or as one-off submission. The one-off submission should contain claims file in the format outlined in segment 3.0 “Encounter Data Set Elements” and a metadata file in the format outlined in segment 6.0 “Media Requirements” of this document.
5. Amendments should be submitted with the Type of Feed ‘ENC’
6. In submission amendment record is identified by Record Type ‘A’. When inserted in MH DW, it inherits the record type of the record it is amending.
7. If the Claim Number + Claim Suffix combination of the ‘A’ record is not found in MH DW, the record will be rejected with error code 11” Active Original Claim No-Claim Suffix Not Found”
8. If the claim that has to be amended already has Former Claim Number information on a line, that Former Claim Number information should be repeated precisely on the amendment claim
9. All columns should be populated according to the standards like any other submitted claim and should contain post-change values
10. All provider data on the claim must point to a provider reference data.
11. A claim submitted prior to the introduction of Commonwealth Care must have valid data in the Group Number field.
12. Multiple amendments to the same record in the same feed are not allowed and will be rejected with error code “10 - Duplicate Claim No-Claim Suffix -- in same feed”.
13. The amendment file loads with the same iterative error process as the regular submission.
14. Dollar amount changes on the claims that happen in the source system, like Replacements and Voids, should be handled via existing process set up to handle those kinds of transactions.

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return error files containing erroneous records back to the MCEs and MBHP for correction and resubmission. The error rate in the initial submission should be no more than 3% for the data to be considered complete and accurate. The format of the error files will be the same as the input record layout described above with 2 fields appended as the last 2 fields on the record layout. These will be the erroneous field number and the error code for that field. Section 8.0 Quantity and Quality Edits, Reasonability and Validity Checks lays out the expectation for each field in the record format for the feed. In addition to these edits, MassHealth will also subject the records to some intra-record validation tests. These may include validation checks like "net amount <= gross amount", "non-unique claim number + claim suffix combination", etc. Error checking is likely to evolve with time therefore a complete list of all pseudo-columns and error codes will accompany the rejected records returned to the MCEs and MBHP. A list is published below.

Error Codes

Error Code	Error Code
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date
6	Admissions Date is greater than Discharge Date
7	Discharge Date is less than Admissions Date
8	Paid Date is less than Admission or Discharge or Service Dates
9	Date is prior to Birth Date
10	Duplicate Claim No-Claim Suffix -- in same feed
11	Active Original Claim No-Claim Suffix Not Found
12	Bad Zip Code
13	Replacement received for a voided record
14	Date is in the future
15	From Service Date is greater than To Service Date

Error Code	Error Code
16	To Service Date is less than From Service Date
17	Cannot be Negative
18	Non HIPAA/Standard code.
19	Bad Metadata File.
20	Local Code Not present in MassHealth DW.
21	Cannot be Zero.
22	Former Claim No-Claim Suffix fields should not contain data for Original Claim
23	Only Original claims allowed in the Initial feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	Filler
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed
27	Metadata - No metadata file found, or file is empty.
28	Metadata - MCE_Id incorrect for the plan.
29	Metadata - MCE_ID not found in metadata file.
30	Metadata - Date_Created not found in metadata file.
31	Metadata - Date_Created is not a valid date.
32	Metadata - Data_File_Name not found in metadata file.
33	Metadata - Data_File_Name does not exist or is not a regular file.
34	Metadata - Pro_file_Name not found in metadata file.
35	Metadata - Pro_file_Name does not exist or is not a regular file.
36	Metadata - Pro_Spec_Name not found in metadata file.
37	Metadata - Pro_Spec_Name does not exist or is not a regular file.
38	Metadata - Total_Records not found in metadata file.

Error Code	Error Code
39	Metadata - Total_Records does not match actual record count.
40	Metadata - Total_Net_Payments not found in metadata file.
41	Metadata - Total_Net_Payments does not match actual sum of dollar amount.
42	Metadata - Time_Period_From not found in metadata file.
43	Metadata - Time_Period_From is not a valid date.
44	Metadata - Time_Period_To not found in metadata file.
45	Metadata - Time_Period_To is not a valid date.
46	Metadata - Return_To not found in metadata file.
47	Metadata - Type_Of_Feed not found in metadata file.
48	Metadata - Type_Of_Feed contains invalid value. Refer to the spec for valid values.
49	Metadata - Metadata - Ref_Services_File_Name not found in metadata file.
50	Metadata - Ref_Services_File_Name does not exist or is not a regular file.
51	Metadata - ATHTYP_File_Name not found in metadata file.
52	Metadata - ATHTYP_File_Name does not exist or is not a regular file.
53	Metadata - GRPNUM_File_Name not found in metadata file.
54	Metadata - GRPNUM_File_Name does not exist or is not a regular file.
55	Metadata - SVCCLS_File_Name not found in metadata file.
56	Metadata - SVCCLS_File_Name does not exist or is not a regular file.
57	Metadata - CLATYP_File_Name not found in metadata file.
58	Metadata - CLATYP_File_Name does not exist or is not a regular file.
59	RefService not found.
60	If former claim number filled in, so must former_claim_suffix.

Error Code	Error Code
70	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (To Service Date >=10/01/2015)
71	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (Discharge Date>=10/01/2015)
72*	(Denial Code not in Denied_Claims file) Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file
73*	Claim Number/Suffix in Denied_Claims file not in Denied_Claims_Reason_Code file
74	Correction to a claim that is not in MH DW
61	Missing Provider NPI – Not used at present
62	Metadata - Pro_MCEType_Name not found in metadata file.
63	Metadata - Pro_MCEType_Name does not exist or is not a regular file.
75	Codes on record are not in sequence

*Applies to the Denied Claims submissions only

All the MCEs including MBHP should resubmit correct records within 5 business days of receiving the error files from MassHealth. This process will be repeated until the number of validation errors is within a 3% threshold. Refer to the "Encounter Data" section of the MassHealth Contract for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements / Encounter Claims Files Submission Requirements

6.1 Format

File Type: PKZIP/WINZIP compressed plain text file

Character Set: ASCII

All submitted files should be **pipe delimited**. Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should follow the record layout specified in section 4.0 where the length represents the maximum length of each field. Padding fields with 0s or spaces is not required.

Note: Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" - a carriage control followed by a new line).

6.2 Regular Monthly Encounter File Submission

Filename

Zip file name should comply with the naming convention "MCE_Claims_YYYYMMDD.zip", where YYYYMMDD - the date of the file submission, and MCE identifies the Plan according to the following:

MCE Identifier / MCE ID Value in Metadata File	Entity (MCE) Name
FLN	Fallon Community Health Plan
NHP	Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan)
HNE	Health New England
BMC	WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan, MCO/ACO)
CHA	Tufts Health Plan (a.k.a. Network Health, MCO/ACO)
MBH	Massachusetts Behavioral Health Partnership
CCA	Commonwealth Care Alliance (SCO)
UHC	United HealthCare (SCO)
NAV	NaviCare
SWH	Molina Healthcare (a.k.a. Senior Whole Health)
TFT	Tufts Health Plan (SCO)
BHP	BMC HealthNet Plan (SCO)
CCI	Commonwealth Care Alliance (One Care)
NWI	Tufts Health Unify (a.k.a. Network Health-One Care)
UCC	United HealthCare Connected (One Care)

Example: "BMC_Claims_20230401.zip"

6.3 Project Related Filename

Names of the files submitted for the special projects should have an extension up to 6 characters after the date part of the name. For example, the files submitted for the J-Code project might have an extension “JCODE” in the name of the file.

Example:

“MCE_Claims_YYYYMMDD_JCODE.zip”

MH DW will give the MCEs specific instructions on the file naming standards related to specific projects.

6.4 The Manual Override File

A manual override file will override many of the claim line rejection edits intended to ensure quality data. Use with caution. Use only in limited circumstances when Plan is confident that the plan data is correct and the edit is wrong, e.g., a new NDC code is used which is not yet included in MassHealth’s reference table.

The manual override file should be named “MCE_Claims_YYYYMMDD_MO.zip” The “_MO” files should be sent only after the MCEs have corrected and re-submitted records rejected when the regular submission file was processed. Corrections should be sent with “ENC” file.

Note: See description of “ENC” in Metadata file paragraph below.

The manual override file should have a file type of EMO in the metadata file.

6.5 Zip File

- Zip File should contain:

- Encounter Data file
- Provider data file
- Provider specialty file
- MCE Internal Provider Type file
- Service Reference file (MBHP Only)
- Service Class Codes file (MBHP Only)
- Authorization Type Codes file (MBHP Only)
- Claim Type Codes file (MBHP Only)
- Group Number Codes file (MBHP Only)
- Metadata file

6.6 Metadata file

An additional file called **metadata.txt** contains the following Key Value Pairs.

	ENC/EMO
MCE_Id="Value" (See MCE Identifier in 6.2 segment table)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_Name="Value"	Mandatory
Pro_MCEType_Name=”Value”	Mandatory
Total_Records="Value"	Mandatory
Total_Net_Payments="Value"	Mandatory
Time_Period_From="Value” (YYYYMMDD)	Mandatory
Time_Period_To="Value" (YYYYMMDD)	Mandatory
Return_To="email address"	Mandatory
Type_Of_Feed="Value" (ENC/EMO)	Mandatory
Ref_Services_File_Name ="Value"	Optional
SVCCLS_File_Name ="Value"	Optional
ATHTYP_File_Name ="Value"	Optional
CLATYP_File_Name ="Value"	Optional
GRPNUM_File_Name ="Value"	Optional

The regular submission and error corrections files should have Type_Of_Feed =”ENC”.
The manual override file should have Type_Of_Feed =”EMO”.

a) Names of the files in the metadata file must match the names of the actual files in submission
b) Send a zero-byte None.txt for missing files, like CLATYP_File_Name or GRPNUM_File_Name for the Plans other than MBHP, and set corresponding field value to "None.txt"
c) A file posted on SFTP server must have a unique name
d) Discrepancy between the actual feed and the values in Total Net Payments or Total Records fields in Metadata file results in rejection of the submission
e) The names of the Metadata file fields should match the spelling suggested in the spec
Example: Total_Net_Payments)
f) From a processing perspective there is no difference between the original submission file, a correction file, and an Amendment file. All these submission types should have Type_ Of_ Feed =”ENC” in metadata file

6.7 Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. SFTP accounts access is restricted to plan users that are approved by MassHealth.

Details of the server are below:

MCE Identifier	Location on SFTP to Place Production File	Location on SFTP to Place Test File
FLN	/fln/ehs_dw/	/fln/test_mco/
NHP	/nhp/ehs_dw/	/nhp/test_mco/
BMC	/bmc/ehs_dw/	/bmc/test_mco/
CHA	/cha/ehs_dw/	/cha/test_mco/
HNE	/gu04/ehs_dw/	/gu04/test_mco/
CCA	/cca/ehs_dw/	/cca/test_mco/
UHC	/uhc/ehs_dw/	/uhc/test_mco/
NAV	/nav/ehs_dw/	/nav/test_mco/
SWH	/swh/ehs_dw/	/swh/test_mco/
TFT	/tft/ ehs_dw/	/tft/test_mco/
BHP	/bhp/ehs_dw/	/bhp/test_mco/
CCI	/cci/ehs_dw/	/cci/test_mco/
NWI	/nwi/ehs_dw/	/nwi/test_mco/
UCC	/uhc/ehs_dw/	/uhc/test_mco/

- Each home directory (/mce/) currently contains sub directories:
- /ehs_dw/ - for exchanging production submissions and error reports and
- /test_mco/ - for exchanging test submissions and error reports; and for sending ad hoc data to MassHealth
-

6.8 Sending Encounter data

Transfer encounter data file in a format and content as described in sections above to the production folder (/ehs_dw/) on the server. When the data transfer is complete, include a zero-byte file called “mce_done.txt”.

- Refrain from sending several files with the same name.
- Only one submission can be placed on the server at any point of time. You may post the next file when the notification of the previous file load is received.
- If a second file is a project specific, please work with MH DW to follow the instructions on file submission related to the project.

6.9 Receiving Error reports

After the data have been processed, error files in ".txt" format with names starting with "err_" will be posted in production folder /ehs_dw/. The process will send a notification regarding the outcome of the data load, as well as the posted error reports, to the email addresses provided in the Metadata file. If you have not received a notification within 7 business days after posting a submission, please contact MassHealth. No notification will be sent if a file could not be processed (errored out)

Note: each time a new file is loaded, the error files are replaced. The error files will remain available on the server for a period of 30 days. MassHealth may need to revise the retention period in the future, based on available disk space on the server.

7.0 Standard Data Values

This section contains tables that identify the standard coding structures for several of the encounter data fields.

NOTE: Tables F, J and L do not exist in these specifications.

Use of Standard Data Values

The tables list all of the standard data values for the fields, with descriptions.

Standard data values are given for the following tables:

- Table A Admit Type (UB)
- Table B Admit Source (UB)
- Table C Place of Service (CMS 1500)
- Table D Place of Service (from UB Type of Bill)
- Table E Discharge Status (UB Patient Status)
- Table G Servicing Provider Type
- Table H Servicing Provider Specialty (CMS 1500)
- Table I Service Category
- I-A: MCO
- I-B: SCO and One Care (ICO)
- I-C: One Care (ICO) - removed
- Table K Bill Classifications – (UB Bill Classification, 3rd digit)
- Table M Present on Admission (UB)
- Table O UB-4 UNIT OF MEASURE

Note: The abbreviation "**NEC**" after a description stands for ***Not Elsewhere Classified***.

TABLE A – Type of Admission (UB)

Table A below represents the Type of Admission (UB):

Value	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information not available

TABLE B – Source of Admission (UB)

Value	Description
1	Physician Referral
2	Clinic/Outpatient Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from SNF
6	Transfer from another Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	Reserved for assignment by the NUBC (end 10/1/07)
B	Transfer from another home health agency
C	Reserved for assignment by the NUBC (end 7/1/10)
D	Transfer from one unit to another - same Hosp
E	Transfer from ambulatory surgical center
F	Transfer from hospice/enrolled in hospice program
A	Reserved for assignment by the NUBC (end 10/1/07)
B	Transfer from another home health agency

For Newborns

The following table represents the values for newborns:

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C – Place of Service (HCFA 1500)

Place of Service Codes for Professional Claims

CMS Database (as of 12/2021)

Value	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients (effective 10/1/05)
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017) The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective 7/1/06)
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a

Value	Place of Service Name	Place of Service Description
		private residence) when receiving health services or health related services through telecommunication technology. This code is effective January 1, 2022, and available to Medicare April 1, 2022.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective 10/1/03)
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive, and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18	Place of Employment-Worksite	A location, not described by any other POS code, owned, or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual. (This code is available for use effective January 1, 2013, but no later than May 1, 2013)
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Value	Place of Service Name	Place of Service Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.

Value	Place of Service Name	Place of Service Description
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective: 10/1/03)

Value	Place of Service Name	Place of Service Description
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (Effective 10/1/03)
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

TABLE D – Type of Bill (from UB Bill Type – 1st & 2nd digits)

Type of Facility (1st digit)

Value	Description
1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health Agency (HHA)
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic (refer to Clinics Only for 2nd digit)
8	Substance Abuse or Specialty Facility
9	Halfway House

Bill Classifications – Facilities (2nd digit)

Value	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Basic Care
6	Complementary Inpatient
7	Complementary Outpatient
8	Swing Beds
9	Halfway House

Bill Classifications – Clinics only (2nd digit)

Value	Description
1	Rural Health Clinic
2	Hospital-based or Freestanding End State Renal Dialysis Facility
3	Freestanding Clinic
4	Other Rehab Facility (ORF) or Community Mental Health Center
5	Comprehensive Outpatient Rehab Facility (CORF)
6-8	Reserved for national assignment
9	Other

Bill Classifications – Specialty Facility (2nd digit)

Value	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
7-8	Reserved for national assignment
9	Other

TABLE E – Discharge Status (UB Patient Status)

Value	Description
01	Discharged alive to home / self-care (routine discharge)
02	Discharged/Transferred to short term general hospital
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to intermediate care facility (ICF)
05	Discharged/Transferred to other facility
06	Discharged/Transferred to home care
07	Left against medical advice
08	Discharged/Transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital
10 – 19	Discharged to be defined at State level if necessary
20	Expired (Did not recover – Christian Science Patient)
21 – 29	Expired to be defined at State level if necessary
30	Still a patient
31 – 39	Still a patient to be defined at State level if necessary
40	Expired at home (Hospice claims only)

Value	Description
41	Died in a medical facility (Hospice claims only)
42	Place of death unknown (Hospice claims only)
43 – 99	Reserved for National Assignment

TABLE G – Servicing Provider Type

Value	Description
00	Placeholder PCP or other Servicing Provider Type not listed
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)

Value	Description
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology

Value	Description
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine
63	Endocrinology/Metabolism
64	Gastroenterology
65	Hematology
66	Infectious Disease
67	Medical Oncology
68	Nephrology
69	Pulmonary Disease
70	Rheumatology

Value	Description
71	Neurological Surgery
72	Nuclear Medicine
73	Obstetrics/Gynecology
74	Ophthalmology
75	Orthopedic Surgery
76	Otolaryngology
77	Pathology
78	Pediatrician (NEC)
79	Pediatric Specialist
80	Physical Medicine and Rehabilitation
81	Plastic Surgery/Maxillofacial Surgery
82	Preventative Medicine
83	Psychiatry/Neurology
84	Radiology
85	Surgeon
86	Surgical Specialist

Value	Description
87	Thoracic Surgery
88	Urology
95	Dentist
96	Dental Specialist
99	Podiatry
100	Unknown Clinic
120	Chiropractor
125	Dental Health Specialists
130	Dietitian
135	Medical Technologists
140	Midwife
145	Nurse Practitioner
146	Nursing Services
150	Optometrist
155	Pharmacist
160	Physician's Assistant

Value	Description
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)
180	Acupuncturist
185	Spiritual Healers
190	Health Educator
200	Transportation
205	Health Resort
210	Hearing Labs
215	Home Health Organization
220	Imaging Center
225	Laboratory
230	Pharmacy
235	Supply Center
240	Vision Center

Value	Description
245	Public Health Agency
246	Rehab Hospital-Inpatient
247	Rehab Hospital-Outpatient
248	Psychiatric Hospital-Inpatient
249	Psychiatric Hospital-Outpatient
250	Community Health Center
301	General Hospital
302	Certified Clinical Nurse Specialist
303	Infusion Therapy
304	Palliative Care Medicine
305	Adult Day Health
306	Adult Foster Care / Group Adult Foster Care
307	Fiscal Intermediary Services (FIS)
308	Personal Care Management Agency
309	Independent Living Centers
310	Day Habilitation

Value	Description
311	Durable Medical Equipment
312	Oxygen And Respiratory Therapy Equip
313	Prosthetics
314	Orthotics
315	Renal Dialysis Clinics
316	Respite Care
317	Intensive Residential Treatment Program (IRTP)
318	Complex Care Management
319	Special Programs
320	Recovery Learning Community (RLCs)
321	Certified Peer Specialist
322	Emergency Services Program (ESP)
323	Community Health Worker
324	Hospital Licensed Health Center
325	Aging Services Access Point (ASAP)
326	Geriatric Mental Health

Value	Description
327	Child Mental Health
328	Deaf and Hard of Hearing Independent Living Services Programs
329	Home Modification Service Providers
330	Transitional Assistance (across settings) Providers
331	Medication Management Providers
332	Substance Abuse Treatment Center
333	Magnetic Resonance Centers
334	Psych Day Treatment
335	QMB (Qualified Medicare Beneficiaries) Only Provider
336	Group Practice Physicians
337	School-Based Clinic or Health Center
338	Billing Agent
C4	Community Behavioral Health Center

TABLE H – Servicing Provider Specialty (from CMS 1500)

Value	Description
01	General Practice
02	General Surgery
03	Allergy / Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
16	Obstetrics / Gynecology

Value	Description
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery

Value	Description
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometrist
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology
48	Podiatrist
49	Ambulatory Surgery Center
50	Nurse Practitioner

Value	Description
51	Med Supply Co w/Certified Orthotist
52	Med Supply Co w/Certified Prosthetist
53	Med Supply Co w/Certified Prosthetist/Orthotist
54	Med Supply Co not included in 51, 52 or 53
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Prosthetist/Orthotist
58	Individuals not included in 55, 56 or 57
59	Ambulance Service Supplier
60	Public Health or Welfare Agency (Federal, State & Local Govt)
61	Voluntary Health Agency (ex: Planned Parenthood)
62	Psychologist
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology

Value	Description
67	Occupational Therapist
68	Clinical Psychologist
69	Clinical Laboratory
70	Multispecialty Clinic or Group Practice
71	Registered Dietician/Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Centers
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
f79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology

Value	Description
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers (i.e.., Drug, & Department Stores)
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gynecologist/Oncologist

Value	Description
99	Unknown Physician Specialty
A0	Hospital
A1	SNF
A2	Intermediate Care Facility
A3	Nursing Facility, Other
A4	HHA
A5	Pharmacy
A6	Medical Supply Co w/Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Dentist
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

TABLE I – A: Service Category (Using the 4B reporting groups)

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health –Inpatient Services
4	Behavioral Health –Diversionary Services *
5	Behavioral Health –Emergency Services Program (ESP) Services
6	Behavioral Health –Mental Health Outpatient Services *
7	Behavioral Health –Substance Abuse Outpatient Services *
8	Behavioral Health –Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility –Ambulatory Care

Value	Description
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services (MBHP Only) *
26	Outpatient Day Services (MBHP Only) *
27	Non-ESP Emergency Services (MBHP Only) *
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services

Value	Description
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth (Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*** Use these categories only for the claims with Dates of Service before 07/01/2010**.

Table I-B: Service Category (Using SCO and One Care reporting groups)

Note: Effective for the services provided on 01/01/2023 and after

To be consistent with service offerings the structure is updated from two tables to one table.

Few Services are only provided through SCO

For the values used prior to 01/01/2023 please refer to "NewMMIS_Encounter_Expanded_Data_set_V4.12"

Value	Description	SCO	One Care
301	Hospital Inpatient	Yes	Yes
302	Behavioral Health (BH) Hospital Inpatient	Yes	Yes
303	Hospital Outpatient	Yes	Yes
304	Behavioral Health (BH) Hospital Outpatient	Yes	Yes
305	Professional	Yes	Yes
306	Vision	Yes	Yes
307	Dental	Yes	Yes
308	Therapy	Yes	Yes
309	Pharmacy/Drugs	Yes	Yes
309B	Pharmacy/Drugs (non-Part D) **GROSS**	Yes	Yes
310	Laboratory, Radiology, Testing	Yes	Yes
311	Institutional Long-Term Care	Yes	Yes
314	Transportation	Yes	Yes
315	Medical Equipment	Yes	Yes

Value	Description	SCO	One Care
316	Hospice	Yes	Yes
317	Case Management	Yes	Yes
318	Other Miscellaneous	Yes	Yes
320	Personal Care Attendant (PCA)	Yes	Yes
325	Home Health	Yes	Yes
330	Adult Foster Care (Including GAFC)	Yes	Yes
335	Adult Day Health	Yes	Yes
340	Day Habilitation	Yes	Yes
345	Frail Elder Waiver (FEW) Services	Yes	No
347	All Other Community LTC	Yes	Yes
350	ASAPs	Yes	Yes

TABLE K – Bill Classifications - Frequency (3rd digit)

Value	Description
0	Nonpayment/Zero Claims
1	Admit thru discharge claim
2	Interim-first claim
3	Interim –continuing claim
4	Interim-last claim
5	Late charges only claim
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/back out of prior claim
9	Final claim for Home Health PPS episode
A	Admission/Election Notice
B	Hospice termination revocation notice
C	Hospice change of provider notice
D	Hospice Void/back out
E	Hospice change of ownership

Value	Description
F	Beneficiary Initiated adjustment claim-other
G	CWF Initiated adjustment claim-other
H	CMS Initiated adjustment claim-other
I	Intermediary adjustment claim (other than PRO or Provider)
J	Initiated adjustment claim-other
K	OIG initiated adjustment claim
L	Reserved for national assignment
M	MSP initiated adjustment claim
N	PRO adjustment Claim
O	Nonpayment/Zero Claims
P-W	Reserved for national assignment
X	Void/back out a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

TABLE M – Present on Admission (UB)

CMS POA Indicator Options and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider was unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

CMS updated as of 12/21

TABLE O – UNIT OF MEASURE

#	Unit	Description	POPS Suggested Rules
1	F2	International Unit (for example, anti-hemophilia factor)	Physician Administered Drug claims only
2	GR	Gram (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
3	ME	Milligrams (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
4	UN	Unit (for tablets, capsules, suppositories, and powder filled vials)	Physician Administered Drug claims
5	ML	Milliliters (for liquids, suspensions, and lotions)	Physician Administered Drug claims **and** Pharmacy
6	EA	Each	Pharmacy claims only
7	GM	Gram	Pharmacy claims only

Unit of Measure Reference

Retail Pharmacy Type

- Source: NCPDP
- Unit of Measure (NCPDP 600-28)
- Valid values: EA, GM, ML

Medical Type:

- Source: CMS Guidance (https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111)
- Valid values: UN, GR, ML, F2, ME

#	Unit	Standard Referenced	Available Link
1	F2	ANSI 5010 837P and ANSI 5010 837I	
2	GR	ANSI 5010 837P and ANSI 5010 837I	
3	ME	ANSI 5010 837P and ANSI 5010 837I	
4	UN	ANSI 5010 837P and ANSI 5010 837I	https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111
5	ML	ANSI 5010 837P, ANSI 5010 837I, and NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
6	EA	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
7	GM	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- File layout format
- Length and data type of the fields
- Reasonability of data
- ICD Version Qualifier (field # 193) is populated on every encounter claim record that has either ICD diagnosis codes or ICD procedure codes.
- All ICD diagnosis and ICD procedure codes on a claim record are consistent with ICD Version Qualifier.

Data Quality

- Each field is checked for quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports

Claims File

#	Field Name	MassHealth Standard
1	Org. Code	100% present and valid per field requirement.
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Entity PIDSL	100% present on all encounters
4	Record Indicator	100% present and valid per field requirement.
5	Claim Number	100% present and valid per field requirement.
6	Claim Suffix	100% present and valid per field requirement.
7	Pricing Indicator	Directions will be provided later, validation standards TBD
8	Recipient DOB	100% present and valid, as compared to encounter service dates
9	Recipient Gender	100% present and valid, as found in Data Elements table
10	Recipient ZIP Code	100% present and valid per field requirement.
11	Medicare Code	Provide if applicable
12	Other Insurance Code	100% present and valid, as found in Data Elements table
13	Submission Clarification Code	Provide on Pharmacy and Provider-Administered Drug claims

#	Field Name	MassHealth Standard
14	Claim Type	100% present and valid for MBHP only
15	Admission Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
16	Discharge Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
17	From Service Date	100% present and valid date on all claims.
18	To Service Date	100% present and valid date on all claims.
19	Primary Diagnosis	100% present and valid ICD codes on all Professional, Institutional (including Long Term Care), Vision, and Transportation claims. See Diagnosis Segment in Data Element Clarifications for additional requirements.
20	Secondary Diagnosis	60% present and valid ICD codes on inpatient facility and 20% present and valid on other records, excluding drug and vision. Not routinely coded on Dental records and LTC. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
24	Type of Admission	100% present and valid value (Admit Type, Table A) on all inpatient claims, Long Term Care claims, and all hospital (institutional) claims with admission.
25	Source of Admission	100% present and valid value (Admit Source, Table B) on all inpatient claims, Long Term Care claims, and all hospital (institutional) claims with admission.
26	Procedure Code	98% present and valid in general but should be 100% present on all professional claims. Procedure Code Indicator match (i.e., if the code is a “CPT or HCPCS Level 1 Code” then the Procedure code indicator should be “2”).
27	Procedure Modifier 1	Provide if available
28	Procedure Modifier 2	Provide if available
29	Procedure Modifier 3	Provide if available
30	Procedure Code Indicator	100% present and valid if Procedure Code field is filled

#	Field Name	MassHealth Standard
31	Revenue Code	98% present and valid on Hospital and Long-Term Care claims only and should be 100% present on all Inpatient claim detail lines
32	Place of Service	100% present and valid value on all professional claims.
33	Type Of Bill	100% present and valid on all Inpatient and Long-Term Care claims
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, LTC claims, all hospital (institutional) claims with admission.
35	FILLER	
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values on Pharmacy claims; and on Hospital and Professional claims when applicable
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume) and on Hospital and Professional claims when applicable.
39	Days Supply	100% present and valid values, only on all prescription drug Pharmacy claims.
40	Refill Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
41	Dispense As Written Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
42	Dental Quadrant	100% present and valid values (1-4), only on dental claims, where applicable
43	Tooth Number	100% present, only on dental claims, where applicable
44	Tooth Surface	100% present, only on dental claims, where applicable
45	Paid Date	100% present and valid date, falls within submitted date range, falls after “Admit, Discharge, To, and From Dates”
46	Service Class	100% present and valid for MBHP only
47	PCP Provider ID	100% present should be an enrolled provider listed in provider enrollment file. Not applicable to MBHP.
48	PCP Provider ID Type	100% present and valid based on PCP Provider ID field. Not applicable to MBHP.
49	PCC Provider ID	Must match PCC Provider ID listed in provider enrollment file.
50	Servicing Provider ID	100% present and valid on all claims except Pharmacy. Should be an enrolled provider listed in provider enrollment file.

#	Field Name	MassHealth Standard
51	Servicing Provider ID Type	100% present and valid on all claims except Pharmacy, Based on Servicing Provider ID field
52	Referring Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
53	Referring Provider ID Type	100% present and valid, only when Referring Provider ID is present
54	Servicing Provider Class	100% present and valid on all records, as found in the Data Elements table.
55	Servicing Provider Type	100% present and valid value (Servicing Provider Type, Table G)
56	Servicing Provider Specialty	100% present and valid value for Professional Claims (Servicing Provider Specialty, Table H)
57	Servicing Provider ZIP Code	100% present and valid
58	Billing Provider ID	100% present and valid on all claims; should be an enrolled provider listed in provider enrollment file.
59	Authorization Type	100% present and valid for MBHP only
60	Billed Charge	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
61	Gross Payment Amount	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
62	TPL Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
63	Medicare Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
64	Copay	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
65	Deductible	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
66	Ingredient Cost	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
67	Dispensing Fee	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
68	Net Payment	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts

#	Field Name	MassHealth Standard
69	Withhold Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
70	Record Type	100% present and valid on all records, as found in the Data Elements table, dollar amount checks
71	Group Number	100% present and valid
72	DRG	100% present and valid value (001 - 495), on Acute Inpatient Hospital claims, when collected by plan.
73	EPSDT Indicator	Not coded at the present time
74	Family Planning Indicator	Not coded at the present time
75	MSS/IS	Not coded at the present time
76	New Member ID (consistent with above data)	100% Present and valid on all claims; not allowed to be missed or invalid.
77	Former Claim Number	100% present and valid, only when Record Type is not O
78	Former Claim Suffix	100% present and valid, only when Record Type is not O
79	Record Creation Date	100% present and valid date
80	Service Category	100% present and valid (Service Category, Table I)
81	Prescribing Prov. ID	100% present and valid on Pharmacy claims. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on Pharmacy claims.
83	Compound Indicator	100% present and valid on prescription drug records
84	Rebate Indicator	100% present and valid on prescription drug records
85	Admitting Diagnosis	100% present and valid value on all Inpatient claims, Long Term Care claims, and all hospital (institutional) claim with admission.
86	Allowable Amount	100% present and valid, financial field with implied 2 decimals, mathematical check with other dollar amounts
87	Attending Prov. ID	100% present should be an enrolled provider listed in provider enrollment file. Inpatient Claims only.
88	Non-covered Days	Provide if applicable

#	Field Name	MassHealth Standard
89	External Injury Diagnosis 1	Provide if available. Consistent with ICD Version Qualifier.
90	Claim Received Date	100% present and valid date
91	Frequency	100% present and valid on Inpatient claims.
92	PCC Provider ID Type	100% present and valid, when PCC Provider ID is present
93	Billing Provider ID _Type	100% present, and valid on all claims.
94	Prescribing Prov. ID _Type	100% present and valid on Pharmacy claims.
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value on Hospital and Long-Term Care claims
97	Discharge Time	100% present and valid value on Hospital and Long-Term Care claims
98	Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
112	Employment	Provide if available
113	Auto Accident	Provide if available
114	Other Accident	Provide if available
115	Total Charges	Provide if available
116	Non-Covered charges	Provide if available
117	Coinsurance	Provide if available
118	Void Reason Code	100% present on all claims with Record Type “V”
119	DRG Description	Provide if applicable
120	DRG Type	Provide if applicable
121	DRG Version	Provide if applicable
122	DRG Severity of Illness Level	Provide if applicable
123	DRG Risk of Mortality Level	Provide if applicable
124	Patient Pay Amount	Provide if applicable
125	Patient Reason for Visit Diagnosis 1	Provide if applicable. Consistent with ICD Version Qualifier.
126	Patient Reason for Visit Diagnosis 2	Provide if applicable. Consistent with ICD Version Qualifier.
127	Patient Reason for Visit Diagnosis 3	Provide if applicable. Consistent with ICD Version Qualifier.
128	Present on Admission (POA) 1	100% present on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
129	Present on Admission (POA) 2	Provide if Diagnosis 2 is available on Hospital and Long-Term Care claims
130	Present on Admission (POA) 3	Provide if Diagnosis 3 is available on Hospital and Long-Term Care claims
131	Present on Admission (POA) 4	Provide if Diagnosis 4 is available on Hospital and Long-Term Care claims
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long-Term Care claims
133	Present on Admission (POA) 6	Provide if Diagnosis 6 is available on Hospital and Long-Term Care claims
134	Present on Admission (POA) 7	Provide if Diagnosis 7 is available on Hospital and Long-Term Care claims
135	Present on Admission (POA) 8	Provide if Diagnosis 8 is available on Hospital and Long-Term Care claims
136	Present on Admission (POA) 9	Provide if Diagnosis 9 is available on Hospital and Long-Term Care claims
137	Present on Admission (POA) 10	Provide if Diagnosis 10 is available on Hospital and Long-Term Care claims
138	Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
139	Present on Admission (POA) 11	Provide if Diagnosis 11 is available on Hospital and Long-Term Care claims
140	Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
141	Present on Admission (POA) 12	Provide if Diagnosis 12 is available on Hospital and Long-Term Care claims
142	Diagnosis 13	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
143	Present on Admission (POA) 13	Provide if Diagnosis 13 is available on Hospital and Long-Term Care claims
144	Diagnosis 14	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
145	Present on Admission (POA) 14	Provide if Diagnosis 14 is available on Hospital and Long-Term Care claims
146	Diagnosis 15	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
147	Present on Admission (POA) 15	Provide if Diagnosis 15 is available on Hospital and Long-Term Care claims
148	Diagnosis 16	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
149	Present on Admission (POA) 16	Provide if Diagnosis 16 is available on Hospital and Long-Term Care claims
150	Diagnosis 17	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
151	Present on Admission (POA) 17	Provide if Diagnosis 17 is available on Hospital and Long-Term Care claims
152	Diagnosis 18	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
153	Present on Admission (POA) 18	Provide if Diagnosis 18 is available on Hospital and Long-Term Care claims
154	Diagnosis 19	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
155	Present on Admission (POA) 19	Provide if Diagnosis 19 is available on Hospital and Long-Term Care claims
156	Diagnosis 20	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
157	Present on Admission (POA) 20	Provide if Diagnosis 20 is available on Hospital and Long-Term Care claims
158	Diagnosis 21	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and LTC claims
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
161	Present on Admission (POA) 22	Provide if Diagnosis 22 is available on Hospital and Long-Term Care claims
162	Diagnosis 23	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
163	Present on Admission (POA) 23	Provide if Diagnosis 23 is available on Hospital and Long-Term Care claims
164	Diagnosis 24	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
165	Present on Admission (POA) 24	Provide if Diagnosis 24 is available on Hospital and Long-Term Care claims
166	Diagnosis 25	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
167	Present on Admission (POA) 25	Provide if Diagnosis 25 is available on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
168	Diagnosis 26	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
169	Present on Admission (POA) 26	Provide if Diagnosis 26 is available on Hospital and Long-Term Care claims
170	Present on Admission (POA) EI 1	Provide if External Injury Diagnosis 1 is available on Hospital and Long-Term Care claims
171	External Injury Diagnosis 2	Provide if available. Consistent with ICD Version Qualifier.
172	Present on Admission (POA) EI 2	Provide if External Injury Diagnosis 2 is available on Hospital and Long-Term Care claims
173	External Injury Diagnosis 3	Provide if available. Consistent with ICD Version Qualifier.
174	Present on Admission (POA) EI 3	Provide if External Injury Diagnosis 3 is available on Hospital and Long-Term Care claims
175	External Injury Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
176	Present on Admission (POA) EI 4	Provide if External Injury Diagnosis 4 is available on Hospital and Long-Term Care claims
177	External Injury Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
178	Present on Admission (POA) EI 5	Provide if External Injury Diagnosis 5 is available on Hospital and Long-Term Care claims
179	External Injury Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
180	Present on Admission (POA) EI 6	Provide if External Injury Diagnosis 6 is available on Hospital and Long-Term Care claims
181	External Injury Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
182	Present on Admission (POA) EI 7	Provide if External Injury Diagnosis 7 is available on Hospital and Long-Term Care claims
183	External Injury Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
184	Present on Admission (POA) EI 8	Provide if External Injury Diagnosis 8 is available on Hospital and Long-Term Care claims
185	External Injury Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
186	Present on Admission (POA) EI 9	Provide if External Injury Diagnosis 9 is available on Hospital and Long-Term Care claims
187	External Injury Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
188	Present on Admission (POA) EI 10	Provide if External Injury Diagnosis 10 is available on Hospital and Long-Term Care claims
189	External Injury Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
190	Present on Admission (POA) EI 11	Provide if External Injury Diagnosis 11 is available on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
191	External Injury Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
192	Present on Admission (POA) EI 12	Provide if External Injury Diagnosis 12 is available on Hospital and Long-Term Care claims
193	ICD Version Qualifier	100 % Present on all Professional and Institutional claims. 100% required on all other claims when at least one ICD diagnosis code or ICD surgical procedure code is submitted.
194	Procedure Modifier 4	Provide if available
195	Service Category Type	100% present and valid
196	Ambulance Patient Count	Provide if applicable
197	Obstetric Unit Anesthesia Count	Provide if applicable
198	Prescription Number	100% present on Pharmacy claims
199	Taxonomy Code	Provide if available
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
202	Bundle Claim Number	100% present if Bundle Indicator=" Y".
203	Bundle Claim Suffix	100% present if Bundle Indicator=" Y.
204	Value Code	Provide on the new-born claim lines
205	Value Amount	Provide when Value Code is present in field # 203
206	Surgical Procedure Code 10	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
207	Surgical Procedure Code 11	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
208	Surgical Procedure Code 12	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
209	Surgical Procedure Code 13	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
210	Surgical Procedure Code 14	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
211	Surgical Procedure Code 15	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
212	Surgical Procedure Code 16	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
213	Surgical Procedure Code 17	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
214	Surgical Procedure Code 18	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
215	Surgical Procedure Code 19	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
216	Surgical Procedure Code 20	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
217	Surgical Procedure Code 21	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
218	Surgical Procedure Code 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
219	Surgical Procedure Code 23	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
220	Surgical Procedure Code 24	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
221	Surgical Procedure Code 25	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
222	Attending Prov. ID Address Location Code	Provide when Attending Prov. ID is present
223	Billing Provider ID Address Location Code	Provide when Billing Provider ID is present
224	Prescribing Prov. ID Address Location Code	Provide when Prescribing Prov. ID is present
225	PCP Provider ID Address Location Code	Provide when PCP Provider ID is present
226	Referring Provider ID Address Location Code	Provide when Referring Provider ID is present
227	Servicing Provider ID Address Location Code	Provide when Servicing Provider ID is present
228	PCC Provider ID Address Location Code	Provide when PCC Provider ID is present

#	Field Name	MassHealth Standard
229	Submission Clarification Code 2	Provide on Pharmacy and Provider-Administered Drug claims
230	Submission Clarification Code 3	Provide on Pharmacy and Provider-Administered Drug claims
231	Unit of Measure	100 % present and valid on Pharmacy and/or Physician-Administered Drug claims
232	Provider Payment	Provide when available
233	Filler	

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
ENTERPRISE DATA MANAGEMENT & ENGINEERING

MEMBER DATA AND MEMBER ENROLLMENT MONTHLY SUBMISSION SPECIFICATIONS

FOR ALL ENTITIES

Version 2.0
August 21, 2023

Revision History

Version	Date	Revision	Author
2.0	08/21/2023	Updated: - Segment 1. Introduction - to address all the entities - Error Code 101 - Description - Fields 3, 11, 29-34, 51-62 – description - Field 22 - description and requirements - Field 23 - Source of Member Ethnicity Hispanic values descriptions - Field 37 – Source of Member Gender Identity value description -Member Submission Metadata File requirements Added: - Error reports section - Member Enrolment file structure, requirements, validations	Alla Kamenetsky Dipika Budhathoki
1.3	6/15/23	Changed the description of the error code 103	Alla Kamenetsky Dipika Budhathoki
1.2	05/10/23	Added 11 fields - “Date …Updated” and “Date Verified” Updated the validation rules – date values validation	Alla Kamenetsky Dipika Budhathoki
1.0	02/22/2023	Draft	Alla Kamenetsky Dipika Budhathoki

Acronym Definitions

Acronym	Definition
ACO	Accountable Care Organization
DS	MassHealth Data Strategy
DUA	Data Use Agreement
EDME	Enterprise Data Management & Engineering (former Data Warehouse)
EOHHS	Executive Office of Health and Human Services
ETL	Extract, Transform, and Load
ICO	One Care Plans
MBHP	Mass Behavioral Health Partnership
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PHI	Protected Health Information
PIDSL	Provider ID Service Location
PII	Personally Identifiable Information
RELD SOGI	Race, Ethnicity, Language, Disability, Sexual orientation, and Gender identity
SFTP	Secure File Transfer Protocol

1. Introduction

MassHealth is working to improve the collection and uniformity of demographic information, including race, ethnicity, language, disability status, sexual orientation, and gender identity (RELD SOGI) in order to advance health equity. To meet the RELD SOGI requirements, the existing Member File structure has been modified – new fields added, and some existing fields modified. Overall, the number of fields in the file layout has increased from 21 to 66; many of the new fields are optional. Finally, additional non-response options have been added to capture important distinctions.

This document outlines the requirements for monthly Member submissions. Specifically, it outlines both the member demographic data requirements for all entities (ACO A/MCO, SCO, One Care, MBHP and ACO B), and the member enrollment data requirements for most entities (ACO A/MCO, SCO, and One Care). It specifies the required file formats, allowed values, validation rules, submission format, etc.

The Member Demographic File represents a snapshot of member demographic information as of the end of a month prior to the submission date. For example, April 30, 2023, is the "snapshot" date for data submitted in May 2023. The snapshot includes information about both current and disenrolled members.

The Member Enrollment File of the Member monthly submissions captures member enrollment with a PCP. Enrollments that end in the beginning of the reporting month should be included in the Member Enrollment file.

2. Entities, Org. Codes, Production Location on SFTP, etc.

Entity Org. Code A	Entity (MCE) Name B	Entity (MCE) Three-Letter Identifier C	Location on SFTP to Place Production File D	Include Member Enrollment file in submission? E
465	Fallon Community Health Plan	FLN	/fln/ehs_dw/	Yes
469	Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan)	NHP	/nhp/ehs_dw/	Yes
997	WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan)	BMC	/bmc/ehs_dw/	Yes
998	Tufts Health Plan (a.k.a. Network Health, MCO/ACO)	CHA	/cha/ehs_dw/	Yes
999	Massachusetts Behavioral Health Partnership	MBH	/mbh/ehs_dw/	No
471	BeHealthy Partnership (a.k.a. Health New England)	HNE	/gu04/ehs_dw/	Yes
501	Commonwealth Care Alliance (SCO)	CCA	/cca/ehs_dw/	Yes
502	United HealthCare (SCO)	UHC	/uhc/ehs_dw/	Yes
503	NaviCare	NAV	/nav/ehs_dw/	Yes
504	Molina Healthcare (a.k.a. Senior Whole Health)	SWH	/swh/ehs_dw/	Yes
505	Tufts Health Plan (SCO)	TFT	/tft/ehs_dw/	Yes
506	BMC HealthNet Plan (SCO)	BHP	/bhp/ehs_dw/	Yes
601	Commonwealth Care Alliance (One Care)	CCI	/cci/ehs_dw/	Yes
602	Tufts Health Unify (a.k.a. Network Health One Care)	NWI	/nwi/ehs_dw/	Yes
604	United HealthCare Connected (One Care)	UCC	/uhc/ehs_dw/	Yes
701	Community Care Cooperative	CCC	/ccc/ehs_dw/	No
702	Steward Health Choice	STW	/stw/ehs_dw/	No

3. Member File Layout and Data Elements

ID	Field Name	Field Description	Field Length	Data Type	Required
1.	Org. Code	Unique ID assigned by MassHealth Enterprise Data Management & Engineering (MH EDME) to each submitting organization (MCE) **This code identifies your organization:** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 BeHealthy Partnership (a.k.a. Health New England) 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 999 Massachusetts Behavioral Health Partnership 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care) 701 Community Care Cooperative 702 Steward Health Choice	3	N	Required
2.	Member ID	The MassHealth ID of the member	12	C	Required
3.	Active Status Indicator	Y/N indicates whether the member has an "Active" enrollment status with the MCE on the last day of the reporting month	1	C	Required
4.	Member Birth Date	Member Date of Birth	8	Date YYYYMMDD	Required
5.	Member Death Date	Member Date of Death	8	Date YYYYMMDD	Provide if applicable
6.	Member First Name	Member first name	100	C	Required
7.	Member Last Name	Member last name	100	C	Required
8.	Member Middle Initial	Member Middle Initial	1	C	Provide if available
9.	Member Gender	Member's Sex (originally listed on birth certificate) The allowed values are **Male, Female, Other**	8	C	Provide if available
10.	Member Ethnicity	This is the Member's Granular Ethnicity. **This field may contain up to ten of the values listed in Column A of the file attached in Appendix** Member ETHNIC Values.	100	C	Provide if available
11.	Member Race	This is the Member's Race. **This field may contain a up to six of the values listed in Column A of the table in Appendix** Member RACE Values**.**	75	C	Provide if available

ID	Field Name	Field Description	Field Length	Data Type	Required
12.	Member Primary Language	This is the Member's preferred Spoken Language. **This field may contain only one of the values listed in Column A of the file attached in Appendix** Member SPOKEN_LANG See Validation requirement for more details.	75	C	Provide if available
13.	Member Address 1	Member Street Address 1	100	C	Required
14.	Member Address 2	Member Street Address 2	100	C	Provide if applicable
15.	Member City	Member City	40	C	Required
16.	Member State	Member State	2	C	Required
17.	Member Zip Code	Member Zip Code	5	C	Required
18.	Homeless Indicator	Y/N. Indicates if the member is homeless	1	C	Provide if available
19.	Communication Access Needs Indicator	Y/N. Indicates if the member has special needs for communicator	1	C	Provide if available
20.	Disability Indicator	Y/N. Indicates if the member has a disability	1	C	Provide if available
21.	Disability Type	Identifies the disability type for a member. This is a place holder until the disability types are clearly defined. Values TBD	30	C	Provide if available
22.	Entity PIDSL	PIDSL(s) of an Entity the member was enrolled in the reporting month Example: 123456789A	10	C	Required
23.	Member Hispanic Ethnicity	This is the member's Hispanic ethnicity. **This field may contain only one of the values listed in Column A of the table in Appendix** Member_HISPANIC_ETHNICITY	8	C	Provide if available
24.	Member Race Detailed	This field should reflect the "free text entry" response for instances where the ACO/MCO has a valid value other than one listed in Member Race (field #11)	255	C	Provide if available
25.	Member Primary Language Detailed	This field should reflect the "free text entry" response for instances where the ACO/MCO has a valid value for preferred spoken language other than one listed in Member_PRIMARY_LANG (field #12)	255	C	Provide if available
26.	Member Written Language	This is the Member's preferred written Language. **This field may contain only any one of the values listed in Column A of the file attached in Appendix** Member_WRITTEN_LANG. See Validation requirement for more details.	8	C	Provide if available
27.	Member Written Language Detailed	This field should reflect the "free text entry" response for instances where the ACO/MCO has a valid value other than one listed in Member_WRITTEN_LANG.	255	C	Provide if available
28.	Member English Proficiency	This is the English proficiency of the member. **This field may contain only one of the values listed in Column A of the table in Appendix** Member_ENGLISH_PROF	8	C	Provide if available
29.	Member Deaf/Difficulty Hearing	HHS disability question #1 "Is member deaf or have serious difficulty hearing?" **This field may contain only any one of the values listed in Appendix** Member_DISABILITY Values	8	C	Provide if available

ID	Field Name	Field Description	Field Length	Data Type	Required
30.	Member Blind/Difficulty Seeing	HHS disability question #2 "Is member blind or does member have serious difficulty seeing, even when wearing glasses?" **This field may contain only any one of the values listed in Appendix** Member_DISABILITY Values	8	C	Provide if available
31.	Member Difficulty Concentrating/Remembering/Making Decisions	HHS disability question #3 "Because of a physical, mental, or emotional condition, does member have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)" **This field may contain only any one of the values listed in Appendix** Member_DISABILITY Values	8	C	Provide if available
32.	Member Difficulty Walking/Climbing Stairs	HHS disability question #4 "Does member have serious difficulty walking or climbing stairs? (5 years old or older)" **This field may contain only any one of the values listed in Appendix** Member_DISABILITY Values	8	C	Provide if available
33.	Member Difficulty Dressing/Bathing	HHS disability question #5 "Does member have difficulty dressing or bathing? (5 years old or older)" **This field may contain only any one of the values listed in Appendix** Member_DISABILITY Values	8	C	Provide if available
34.	Member Difficulty Doing Errands	HHS disability #6 "Because of a physical, mental, or emotional condition, does member have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older **This field may contain only any one of the values listed in Appendix** Member DISABILITY Values	8	C	Provide if available
35.	Member Sexual Orientation	This is the member's current sexual orientation. **This field may contain up to nine of the values listed in Column A of the table in Appendix** Member_SEXUAL_ORIENT Values**.** See Validation requirement for more details.	75	C	Provide if available
36.	Member Sexual Orientation Detailed	This field should reflect the "free text entry" response for instances where the ACO/MCO has a valid value other than one listed in Member_SEXUAL_ORIENT Values**.**	255	C	Provide if available
37.	Member Gender Identity	This is the member's current gender identity. **This field may contain up to ten of the values listed in Column A of the table in Appendix** Member_GENDER_IDENTITY Values**.** See Validation requirement for more details.	125	C	Provide if available
38.	Member Gender Identity Detailed	This field should reflect the "free text entry" response for instances where the ACO/MCO has a valid value other than one listed in CDE_GENDER_IDENTITY	255	C	Provide if available
39.	Date Updated Race	Date that Race was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
40.	Date Verified Race	Date that Race was last verified by the plan	8	Date YYYYMMDD	Provide if available
41.	Date Updated Ethnicity	Date that Granular Ethnicity was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available

ID	Field Name	Field Description	Field Length	Data Type	Required
42.	Date Verified Ethnicity	Date that Granular Ethnicity was last verified by the plan	8	Date YYYYMMDD	Provide if available
43.	Date Updated Hispanic Ethnicity	Date that Hispanic Ethnicity was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
44.	Date Verified Hispanic Ethnicity	Date that Hispanic Ethnicity was last verified by the plan	8	Date YYYYMMDD	Provide if available
45.	Date Updated English Proficiency	Date that English Proficiency was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
46.	Date Verified English Proficiency	Date that English Proficiency was last verified by the plan	8	Date YYYYMMDD	Provide if available
47.	Date Updated Written Language	Date that Written Language was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
48.	Date Verified Written Language	Date that Written Language was last verified by the plan	8	Date YYYYMMDD	Provide if available
49.	Date Updated Primary Language	Date that Primary Language was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
50.	Date Verified Primary Language	Date that PRIMARY LANGUAGE was last verified by the plan	8	Date YYYYMMDD	Provide if available
51.	Date Updated Member Deaf/Difficulty Hearing	Date that Disability Deaf was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
52.	Date Verified Member Deaf/Difficulty Hearing	Date that Disability Deaf was last verified by the plan	8	Date YYYYMMDD	Provide if available
53.	Date Updated Member Blind/Difficulty Seeing	Date that Disability Blind was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
54.	Date Verified Member Blind/Difficulty Seeing	Date that Disability Blind was last verified by the plan	8	Date YYYYMMDD	Provide if available
55.	Date Updated Member Difficulty Concentrating/	Date that Disability Remembering was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available

ID	Field Name	Field Description	Field Length	Data Type	Required
	Remembering/Making Decisions				
56.	Date Verified Member Difficulty Concentrating/Remembering/Making Decisions	Date that Disability Remembering was last verified by the plan	8	Date YYYYMMDD	Provide if available
57.	Date Updated Member Difficulty Walking/Climbing Stairs	Date that Disability Walking was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
58.	Date Verified Member Difficulty Walking/Climbing Stairs	Date that Disability Walking was last verified by the plan	8	Date YYYYMMDD	Provide if available
59.	Date Updated Member Dressing/Bathing	Date that Disability Dressing was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
60.	Date Verified Member Dressing/Bathing	Date that Disability Dressing was last verified by the plan	8	Date YYYYMMDD	Provide if available
61.	Date Updated Member Difficulty Doing Errands	Date that Disability Errands was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
62.	Date Verified Member Difficulty Doing Errands	Date that Disability Errands was last verified by the plan	8	Date YYYYMMDD	Provide if available
63.	Date Updated Sexual Orientation	Date that Sexual Orientation was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
64.	Date Verified Sexual Orientation	Date that Sexual Orientation was last verified by the plan	8	Date YYYYMMDD	Provide if available
65.	Date Updated Gender Identity	Date that Gender Identity was originally entered or changed by the plan	8	Date YYYYMMDD	Provide if available
66.	Date Verified Gender Identity	Date that Gender Identity was last verified by the plan	8	Date YYYYMMDD	Provide if available

4. Member Data Requirements and Validation Rules

4.1. Records will be rejected if:

4.1.1. Member ID is missing or invalid.
4.1.2. Org. Code is missing or invalid.
4.1.3. Org. Code is not meeting MassHealth Standards.
4.1.4. Entity Identifier (PIDSL) is not a valid MassHealth ID.
4.1.5. Incorrect value separator is used in multiple values fields.
4.1.6. Suggested value format is not followed. Example: date fields should always be formatted as 'YYYYMMDD'.
4.1.7. Date values are invalid. For example: 20230231 (Feb 31st, 2023)
4.1.8. The number of values in fields 9 thru 12, and fields 23, 26, 28-35, and 37 is greater than the maximum number allowed.
4.1.9. Any value in fields 10-12, 23, 26, 28-35, and 37 is not from the suggested list.
4.1.10. Duplicate record for the same Member ID in the file.

4.2. MCEs should endeavor to provide complete data in all fields, even in the fields where values are requested "when available", like in "Member Ethnicity" (field #10), "Member Race" (field #11), and "Member Primary Language" (field #12).

4.3. Semi-colon (;) should be used to separate the values in the fields that allow multiple values. For example, values in "Member Gender Identity" (field #37) can be submitted as "OTH; 407377005".

4.4. Null values are allowed in all fields that are not required.

5. Member Data Load Error Handling

Error Code	Error Description
101	Duplicate Record/MassHealth Member ID and Entity PIDSL
102	The value is missing
103	Invalid Format or not meeting MH standards
104	Incorrect data type
105	More than allowed number of values
106	At least one value is not from reference list
107	Invalid date

6. Member Enrollment File Layout and Data Elements

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MassHealth Enterprise Data Management & Engineering (MH EDME) to each submitting organization (MCE) **This code identifies your organization** 465 Fallon Community Health Plan 469 Mass General Brigham Health Plan (a.k.a. Allways Health Partners, a.k.a. Neighborhood Health Plan) 471 Health New England 997 WellSense Health Plan (a.k.a. Boston Medical Center HealthNet Plan) 998 Tufts Health Plan (a.k.a. Network Health, MCO/ACO) 501 Commonwealth Care Alliance (SCO) 502 United HealthCare (SCO) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan (SCO) 506 BMC HealthNet Plan (SCO) 601 Commonwealth Care Alliance (One Care) 602 Tufts Health Unify (a.k.a. Network Health-One Care) 604 United HealthCare Connected (One Care)	3	N	Required	
2	Member ID	The MassHealth ID for the member	12	C	Required	
3	Provider Enroll Type	This field indicates the Type of Provider a member is enrolled with. It should reflect the information entered in the Provider ID and ID Type. For example, if Provider Enroll Type is entered as '02' then the Provider ID and ID Type should be for the "Geriatric Coordinator" the member is enrolled with. The values are as follows: 01 = PCP 02 = Geriatric Coordinator 03 = LTSS Coordinator 04 = Care Coordinator 05 = Care Coordination Program (if no assigned care coordinator but member is enrolled in a care coordination program) 06 = Care Manager 07 = Care Management Program (if no assigned care manager but member is enrolled in a care management program)	2	C	Required	This is a key field, and it indicates whether the provider fields are for a PCP or CM providers.

#	Field	Description	Length	Type	Required	Comments
4	Provider Enroll Type Description	The Description of the Provider Enroll Type. The description should be consistent with the value selected in Provider Enroll Type. If the value entered in Provider Enroll Type is " 01" the description should be "PCP" If the value entered in Provider Enroll Type is "02" the description should be " Geriatric Coordinator" and so on.	40	C	Required	
5	Care Level	This field is required with all CM Providers to indicate whether the Provider ID submitted is at the MCE or Practice/Provider level. If the Provider is a PCP, value "NA" must be entered in this field. Values are: "MCE" "PRV" "NA" for "Not Applicable"	3	C	Required	
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	
7	End Enrollment Date	This is the end enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	This value should be "99991231" for "active" enrollment which represents End of Time (EOT).
8	Provider ID	Provider ID	15	C	Required	This ID should be consistent with the ID submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type value was submitted on a record as "01" then the Provider ID for that record would be for a PCP. This applies to all other values in the Provider Enroll Type.
9	Provider ID Type	Provider ID Type is required when the provider is part of prior and current provider files submitted in the encounter data. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Required	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a provider.

#	Field	Description	Length	Type	Required	Comments
						Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type value was submitted on a record as "01" then the Provider ID Type for that record would be the ID Type associated with a PCP. This applies to all other values in the Provider Enroll Type.
10	Practice ID	Practice ID.	15	C	Highly important so please provide if available	This ID should be consistent with the ID submitted in the Encounter Provider File for a Practice
11	Practice ID Type	Practice ID Type. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Highly important so please provide if available	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a Practice
12	Provider ID Address Location Code	Code to identify address location of Provider ID in Field #8	15	C		
13	Practice ID Address Location Code	Code to identify address location of Practice ID in Field #10.	15	C		
14	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims SCO PIDSL on SCO claims One Care PIDSL on One Care claims Example: 999999999A	10	C	Required on all records	Should be consistent with ACO PIDSL submitted in the encounter provider file

7. Member Enrollment Data Requirements

7.1. Each MCE (except MBHP, Community Care Cooperative, and Steward Health Choice) should submit a full refresh of all MassHealth members who have been enrolled with a PCP including enrollments that ended on the first day of a submission month.

7.2. The file should include all enrollments. For example, if a member had three PCP enrollments during this period, all three enrollments will be reported in the file.

7.3. Begin and End Enrollment dates must reflect changes in member enrollment with a PCP and changes in Practice affiliation.

7.4. Members who are enrolled with an MCE and are in the Member File, but do not have PCP enrollment should not be included in Member Enrollment file.

7.5. All members included in the Member Enrollment File should also be included in the Member File.

7.6. Any member enrollment record that existed in prior files and is not submitted in the current file get "soft" deleted from MassHealth system.

8. Member Enrollment File Providers and Practices

8.1. PCPs are considered "Providers", and their IDs should be submitted in the Provider ID field.
8.2. The Practice that the above providers are associated with is referred to as "Practice", and the Practice Provider ID should be submitted in the Practice ID field.
8.3. If one Practice location cannot be identified for the member enrollment with a PCP then MCEs should provide the ID for the PCP's head contracting entity in the Practice ID field.
8.4. A "Provider Enroll Type" field indicates that the Provider ID is for a PCP.
8.5. A "Care Level" field indicates whether the CM Provider IDs are submitted at the MCE or Practice/Provider level.
8.6. The only information required in the Member Enrollment File for a Provider and Practice is Provider ID/Provider ID Type and Practice ID/Practice ID Type.
8.7. Every Provider ID for a PCP and every Practice ID must exist in Provider File included in Encounter submission file.
8.8. A change in **Provider or Practice** demographic information does not require submission of a new record in the Member Enrollment File. Provider and Practice demographic information is maintained in the Encounter Provider File.

9. Member Enrollment File Begin and End Enrollment Dates

9.1. The Member Enrollment File will have "Begin" and "End" Enrollment Dates to identify all enrollments with a PCP.

9.2. Any change in the member enrollment with a provider would require additional records with new "Begin" and "End" Enrollment dates.

9.3. "Begin" and "End" enrollment dates must be submitted with each record. End Enrollment Date for "active" enrollments with a provider will be submitted as "End of Time" (EOT – 99991231)

10. Member Enrollment Data Validation Rules

10.1. All Member IDs submitted in the Member Enrollment File must exist in MMIS

10.2. All Member IDs submitted in the Member Enrollment File must exist in Member File

10.3. The records get rejected if:

- 10.3.1. Member ID is missing or invalid
- 10.3.2. Provider ID is missing or invalid (not found in MCE Provider Files)
- 10.3.3. Provider ID Type is missing or invalid (not found in MCE Provider Files)
- 10.3.4. Provider ID address location code is missing or invalid (not found in MCE Provider Files)
- 10.3.5. Practice ID Type or Practice ID Address Location Code is missing when Practice ID is provided
- 10.3.6. Practice ID Type not found in MCE Provider File
- 10.3.7. Provider Enroll Type is missing
- 10.3.8. Provider Enroll Type is not valid as per specification
- 10.3.9. Care Level is missing or is not valid as per specification
- 10.3.10. Begin Enrollment Date is missing or invalid
- 10.3.11. End Enrollment Date is missing or invalid
- 10.3.12. Org. Code is missing or invalid

10.4. Member Enrollment File data are not used in claims validation process.

10.5. Rejected Member Enrollment File records do not affect encounter claims data load.

10.6. Records are currently not rejected if the values in other fields are missing or invalid; however, these fields are very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

10.7. Since Provider information in Member enrollment file is validated against the data in Provider file, Member submission should be posted after encounter submission is processed.

11. Submission Process

11.1. Monthly submission should be zipped in a file named “MCE_Member_YYYYMMDD.zip” (e.g., CCC_Member_20230725.zip). For a three-letter entity identifier see Table 1, column C.

11.2. Member ZIP File must include Member data File, Member Enrollment File, and Member Metadata File.

11.3. Member File and Member Enrollment files must be submitted in requested format as “pipe” delimited text file with no column names.

11.4. Member Metadata File must be named “MEM_metadata.txt”.

11.5. Member production submission should be placed on SFTP server in “ehs_dw” directory (e.g., /ccc/ehs_dw/).

11.6. A zero-byte file "mem_mce_done.txt" must be placed along with the Member Zip file in “ehs_dw” directory

12. Member Submission Metadata File

Metadata Field	Submission	Comment
MCE_Id="Value"	Mandatory	A three-letter Entity identifier. Examples: “CCC”, or “STW”, or “BMC”, etc.
Date_Created=" YYYYMMDD"	Mandatory	The date when the file was created.
Member_File_Name="Value"	Mandatory	A name of an actual member data file in submission.
MemEnroll_File_Name="Value"	Mandatory	A name of an actual enrollment data file in submission. Should have a value of “none.txt” in MBH, CCC, and STW submissions.
CareMgmt_File_Name="Value"	Mandatory	Should have the value of “none.txt”.
Total_Member_Records="Value"	Mandatory	Total number of records in Member data file.
Total_MemEnroll_Records="Value"	Mandatory	Total number of records in Mem Enroll File. Should have a value of zero in MBH, CCC, and STW submissions
Total_CareMgmt_Records="Value"	Mandatory	Should be zero.
Time_MemEnroll_From="Value" (YYYYMMDD)	Mandatory	The earliest “Begin Enrollment Date” in the Member Enrollment File. For submissions with no Mem Enroll File – date in Date_Created field above.
Return_To=”Email Address”	Mandatory	An email address that all submission related correspondence between MassHealth and the MCEs will be sent to; can be a list of addresses included in double quotes and separated by coma.

13. Member Submission Files Loads

13.1. Each time zip file is processed, a notification is sent to let MCE know the status of the submission.

13.2. Submissions that do not meet specification standards get rejected.

13.3. Submissions where metadata are not consistent get rejected.

13.4. Rejected files have to be corrected and re-submitted.

13.5. All records in Member File and Member Enrollment File not meeting validation rules get rejected.

13.6. Rejected Member data and Member Enrolment records are sent back in error reports to “ehs_dw” directory.

13.7. Error reports with no records will be generated for the submissions with no errors.

13.8. Rejected records should be corrected and reposted in the same format as the original files.

13.9. Records with errors never get into MassHealth system.

14. Error Reports

14.1. Member data Error Files:

14.1.1. Detail error report that repeats the member file format with two additional columns on the right: one - for the number of the field with the error, and another - for rejection reason code. A record can be repeated in the detail report as many times as many errors occurred.
Report name example: “err_member_MCE.2023.07.03.19.37.04.**detail**.txt”.

14.1.2. Summary error report consists of two parts:
Part -I. Frequency of rejected records by field name and error code.
Part -II. Submission Stats Summary – zip file name, number of submitted records, number of rejected records, number of the loaded records, etc.
Report name example: - “err_member_MCE.2023.07.03.19.37.04.**summary**.txt”.

14.2. Member Enrollment Error File

14.2.1. Member enrollment error report repeats the member enrollment file format with one additional column on the right for rejection reason code.

14.2.2. Report name example: “err_MCE_memenroll_YYYYMMDD.txt”. (e.g., ERR_BMC_MEMENROLL_20230531.txt).

14.2.3. Some of the error codes in the Member enrolment error report:

- ENROLL_BEGIN_DATE is invalid or missing
- ENROLL_END_DATE is invalid or missing
- ID_MEDICAID does not exist in EHS Datawarehouse
- Provider Unique identifier (PROVIDER_ID&PROVIDER_ID_TYPE&PROVIDER_ID_LOC_CODE) is invalid or missing values on the provider record

15. Appendixes

15.1. Member Ethnicity (Field #10) Values and Descriptions

CDE_ETHNIC_VALUES_USCDIv3.xlsx

15.2. Member Race (Field #11) Values and Descriptions

Valid Value A	Value Description B
1002-5	American Indian or Alaska Native
2028-9	Asian
2054-5	Black or African American
2076-8	Native Hawaiian or Other Pacific Islander
2106-3	White
OTH	Race is not listed here
ASKU	Member was asked to provide their race, and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked to provide their race, and the member actively selected or indicated that they did not know their race
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNK	The race of the member is unknown since either: (a) the member was not asked to provide their race, or (b) the member was asked to provide their race, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK

15.3. Member Primary Language (field#12) values and Descriptions

CDE_SPOKEN_LANG_VALUES_USCDIv3.xls›

15.4. Member Written Language (Field #26) values and Descriptions

CDE_WRITTEN_LANG_VALUES_USCDIv3.xls

15.5. Member Ethnicity Hispanic (Field#23) Values and Descriptions

Valid Value A	Description B
2135-2	Hispanic or Latino
2186-5	Not Hispanic or Latino
ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNK	The ethnicity of the member is unknown since either: (a) the member was not asked to provide their ethnicity, or (b) the member was asked to provide their ethnicity, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response and should be assigned the value of ASKU instead of UNK.

15.6. Member English Proficiency (Field#28) Values and Descriptions

Valid Value A	Description B
VERWELL	Very well
WELL	Well
NOTWELL	Not well
NOTALL	Not at all
ASKU	Member was asked to provide their English Proficiency, and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked to provide their English proficiency, and the member actively selected or indicated that they did not know their English proficiency.
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNKNOW	The English Proficiency of the member is unknown since either: (a) the member was not asked to provide their English Proficiency, or (b) the member was asked to provide their English Proficiency, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response and should be assigned the value of ASKU instead of UNK.

15.7. Member Disability Deaf, Blind, Remembering, Walking, Dressing, Errands (Fields #29 - #34) Values and Descriptions

Valid Value A	Description B
LA33-6	Yes
LA32-8	No
ASKU	Member was asked [1 of 6 questions regarding disability], and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked [1 of 6 questions regarding disability], and the member actively selected or indicated that they did not know the answer.
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNK	Whether a member has [1 of 6 disabilities] is unknown since either: (a) the member was not asked [a given disability question], or (b) the member was asked [a given disability question], and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK

15.8. Member Sexual Orientation (Field #35) Values and Descriptions:

Valid Value A	Description B
42035005	Bisexual
20430005	Straight or heterosexual
38628009	Lesbian or gay
QUEER	Queer, pansexual, and/or questioning
OTH	Sexual orientation is not listed here
ASKU	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they did not know their sexual orientation.
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNK	The sexual orientation of the member is unknown since either: (a) the member was not asked to provide their sexual orientation, or (b) the member was asked to provide their sexual orientation, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response and should be assigned the value of ASKU instead of UNK.

15.9. Member Gender Identity (Field #37) Values and Descriptions

Valid Value A	Description B
446151000124109	Male
446141000124107	Female
446131000124102	Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female
407376001	Transgender man/trans man
407377005	Transgender woman/trans woman
OTH	Gender identity is not listed here
ASKU	Member was asked to provide their gender identity, and the member actively selected or indicated that they "choose not to answer."
DONTKNOW	Member was asked to provide their gender identity, and the member actively selected or indicated that they did not know their gender identity.
UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness)
UNK	The gender identity of the member is unknown since either: (a) the member was not asked to provide their gender identity, or (b) the member was asked to provide their gender identity, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a is a valid response and should be assigned the value of ASKU instead of UNK.

APPENDIX I
CREDENTIALING WEBSITES AND TIBCO

Website or Database	Go to:	What is Checked	Frequency
List of Suspended or Excluded MassHealth providers	http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html	All providers which have been suspended or excluded by MassHealth	At enrollment & revalidation and as needed for all provider types
NPI – National Provider Identifier Verify provider's NPI	https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do	NPI Number, First Name, Last Name may be entered to verify that the provider is on the NPI database	At enrollment & revalidation and as needed for all provider types
OIG – CMS Office of Inspector General Verify exclusions	http://exclusions.oig.hhs.gov	Last name and first name are entered to see if there are any findings under the provider's name	At enrollment, revalidation & monthly for all provider types
Massachusetts Board of Registration in Medicine (BORIM) Validate licenses, suspensions and actions	http://profiles.ehs.state.ma.us/Profiles/Pages/FindAPhysician.aspx	You may search by Name, Specialty, License Number or ZIP Code to validate the license and verify if findings are present that would prevent them from practicing in MassHealth	At enrollment, revalidation & weekly for all provider types

Website or Database	Go to:	What is Checked	Frequency
DEA Number Verify DEA number	https://www.deanumber.com	Last name, State if the provider is found, verify that the provider's DEA number is current and without issue.	At enrollment & revalidation for all providers with a DEA
MedFile Verify exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	Last name, first name are searched from the drop-down option to ensure the provider's name is not listed and that there are no current findings against them.	At enrollment, revalidation & monthly for all provider types
PEC States Verify other state's exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	View by last name, first name, and state to view termination data from CMS	At enrollment, revalidation & monthly for all provider types
DIA – Debarment List Verify debarments	http://www.mass.gov/lwd/workers-compensation/investigations/swos-issued.html	View debarment information by company name, address, city, and state to assure a provider is not listed	At enrollment & revalidation for all provider types

Website or Database	Go to:	What is Checked	Frequency
Licenses Verify exclusions	http://license.reg.state.ma.us/public/licque.asp?color=blue Or https://checkalicense.hhs.state.ma.us/mylicenseverification/Search.aspx?facility=N	Verify individuals' licenses by number / business info / personal info to verify the license is current and there are no findings against the ID	At enrollment & revalidation for all provider types when there is a hit on Sam, LEIE, MedFile, OIG At enrollment, revalidation, and monthly for BORID
SAM – System for Award Management	https://sam.gov/portal/SAM/#1	Enter the provider's last name then first name to verify that the provider is not on the SAM website	At enrollment, revalidation & monthly for all provider types
Death Master File Verify a provider is not listed as deceased	Download file with a subscription	Enter the provider's name and/or social security number to verify that any applicant or Reval provider is not on the death file	At enrollment & revalidation for all provider types
CORI Submit verify any criminal record the within the State of Massachusetts You must have a user ID to access CORI	https://icori.chs.state.ma.us/icori/ext/login/login.action?_p=jrSw8VW0a8WNvtHhCjMVj3RacRdmZmDDlpMkSxSL5Iw	The CORI Request Form is to be completed by the provider types 07 or 61 submitted as part of their application to the CSC. All of the information on the form is entered. Access to CORI is limited and must be processed by those with access.	At enrollment & revalidation for applicable providers

Website or Database	Go to:	What is Checked	Frequency
JCAHO (Joint Commission) Verify provider's accreditation/certification status	http://www.qualitycheck.org/consumer/searchQCR.aspx#	You may search a provider based on name, zip code or state. JCAHO is checked for hospital that are applying or being revalidated as is required for complete credentialing.	At enrollment, revalidation and monthly for hospitals
NBCOT (Nat'l Board for Certification in Occupational Therapy Validate licenses and suspensions and actions	https://my.nbcot.org/OnlineCredentialVerification/	The certification page requests either the certification number or last name, first name. The results are reviewed for whether the provider is Active and if there are any actions against them currently or in the past.	At enrollment, revalidation and monthly for therapists

Website or Database	Go to:	What is Checked	Frequency
ASHA (American Speech-Language-Hearing Assn.) Validate licenses and suspensions and actions	http://www.asha.org/eweb/ashadynamicpage.aspx?webcode=ccchome	The ASHA certification page requires either the 8-digit ASHA account number or the provider's first and last name as well as their state. The provider must be licensed by the Board of Speech and Language Pathology as well as be accredited by ASHA.	At enrollment, revalidation & monthly for hearing instrument specialists
CHAP (Community Health Accreditation Program) Validate licenses and suspensions and actions	http://www.chapapps.org/search/	The CHAP website is used to find an accredited Community Health Provider. The home page may be searched by either the Agency Name or by State. The results display the Organization, City and State, Accreditation Dates, and Services.	At enrollment, revalidation & monthly for CHCs

Website or Database	Go to:	What is Checked	Frequency
American Board of Opticianry Certification Validate licenses and suspensions and actions	http://www.abo-ncle.org/ABO/Certification/Search_Certification_Database/ABO/PublicQueries/Certification_Database.aspx	The ABO certification database is searched by last name, first name, city, state and zip. The results will display the Certificate holder, Company, Certification, City, State, ZIP, Status, and Expiration date.	At enrollment, revalidation & monthly for opticians
National Examining Board of Ocularists Validate licenses and suspensions and actions	http://www.neboboard.org/nebostaprov.htm	This website displays the National Registry of Board Certified Ocularists. There is no way to search by individual name.	At enrollment, revalidation & monthly for Ocularists
State of New Hampshire Board Actions Validate licenses and suspensions and actions	http://www.nh.gov/medicine/aboutus/actions/index.htm	The provider's name and /or license number is listed on the home page and then searched. Results will indicate the provider's license, start date, end date, expiration date, specialty, and schooling. It will also show "Remarks" indicating "status" such as inactive or dead.	At enrollment, revalidation & weekly verifications

Website or Database	Go to:	What is Checked	Frequency
State of Rhode Island Board Actions Validate licenses and suspensions and actions	http://www.health.ri.gov/lists/disciplinaryactions/	The disciplinary actions page has 3 options for search; License type, Find by Name, or Filter by Date. Results are reviewed for matches to any Massachusetts providers.	At enrollment, revalidation & weekly verifications
State of Connecticut Board Actions Validate licenses and suspensions and actions	http://www.ct.gov/dph/cwp/view.asp?a=4061&q=387280	The CT DPH displays a Regulatory Action Report that posts actions taken against providers by calendar year and quarter. There are 25 quarters posted which have to be searched individually.	At enrollment, revalidation & weekly verifications Usually updated quarterly

Website or Database	Go to:	What is Checked	Frequency
State of New York Board Actions Validate licenses and suspensions and actions	http://w3.health.state.ny.us/opmc/factions.nsf http://www.op.nysed.gov/opd/rasearch.htm	The NY BOH has a search page for Board Action regarding a particular Physician or Physician Assistant. The physician or PA may be entered with the last name; the license number may be searched; the license type may be searched; or the search may be done by entering the effective date of the disciplinary action.	At enrollment, revalidation & weekly verifications
State of Vermont Board Actions Validate licenses and suspensions and actions	http://healthvermont.gov/hc/med_board/actions.aspx	The Vermont DPH site has a page that is for Board Actions by Month. Yearly actions may be reviewed historically back to 2006 by month. There is no board action search by individual alone.	At enrollment, revalidation & weekly verifications

Website or Database	Go to:	What is Checked	Frequency
State of Maine Board Actions Validate licenses and suspensions and actions	http://www.maine.gov/md/discipline/adverse-licensing-actions.html	The State of Maine Board of Licensure in Medicine displays a page titled "Adverse Licensing Actions". These actions are displayed by year with no search ability by individual alone.	Weekly verifications
MA Nursing Board Actions Validate licenses and suspensions and actions	https://checkalicense.hhs.state.ma.us/MyLicenseVerification/	The MA License Verification Site has search options for Profession, License Type, Name, License Number, and Status. For nursing searches the top three options for license status will be Suspension, Revocation and Probation.	Monthly verifications

APPENDIX J
SCO MMIS INTERFACES

All Interfaces from, or to, a SCO Plan and MMIS have been defined as batch interfaces (as opposed to transactional).

All HIPAA transactions will be in **X12 format**. All non-HIPAA interfaces will be in **XML format**.

Appropriate Channels for interfacing of batch transactions include:

1. HTTP MIME and SOAP system to system connection

2. Provider Online Service Center (POSC)

3. Another method specified by EOHHS

Listed below is a short description of each of the interfaces from, or to, MMIS and the SCO Plans. Note that the terms INBOUND and OUTBOUND are used to denote the flow of data relative to MMIS. Inbound is data coming from a SCO Plan to MMIS, and outbound is data coming from MMIS to a SCO Plan.

A. Inbound Interfaces

1. Provider Online Service Center (POSC): SCO plans are responsible for sending enrollments and disenrollments via the POSC for any enrollments or disenrollments effective January 1, 2026, or after.
2. Provider Enrollment Input File: This file is part of the MCE Provider enrollment process and must be submitted to MassHealth at least once a month. The enrollment file includes all the required and optional fields to enroll a provider in the MMIS.

B. Outbound Interfaces

1. HIPAA 834 Outbound Daily File

   On a daily basis, MMIS will transmit the HIPAA 834 enrollment transactions to the Contractor. The 834 is the mechanism by which MMIS communicates to SCO plans changes in member information including but not limited to: enrollee name, DOB, gender, address, Medicare, changes to aid category segment beginning and end date (eligibility), changes to enrollment segment beginning and end dates.

2. HIPAA 834 Outbound Monthly File

On a monthly basis, MMIS will transmit a full set of all enrollment transactions to the Contractor. This gives the Contractor a mechanism to verify that its enrollment files and MMIS enrollment files are synchronized. This audit file will send the most current information available which will include any Enrollee updates that took place during the previous month.

3. HIPAA 820 File

   On a scheduled monthly basis, MMIS will transmit HIPAA 820 payment confirmations.

4. Provider Enrollment Response Files

   There will be one response file for every uploaded Provider Enrollment file. These files are part of the MCE Provider Enrollment Process:

   a. Successful Response File: The Successful Response file includes an NPI and the MMIS generated Application Tracking Number (ATN) for all the Providers that were submitted in the Enrollment input file

   b. Errors Response File: The Errors Response file will be generated if the input file fails for either XML Schema validation Errors, meaning the file or data is not in the proper format, or for any MMIS application edits.

APPENDIX K
SCO MATERIAL SUBCONTRACTOR CHECKLIST

Below is a list of questions related to [***insert name of SCO Plan***] preparedness for entering into a contract with a Material Subcontractor [***Insert name and type of subcontractor***]. **The Contractor shall provide a written response to these questions as instructed for Readiness Review and during the Contract Term for new Material Subcontractors, no later than 60 days prior to contract execution.** (See also **Appendix A**.)

Name of MCE: Date of Submission:

Date of Resubmissions (if applicable):

SECTION 1

Please answer all questions completely. If a question is not applicable, insert N/A throughout.

GENERAL INFORMATION

1. What is the name of the Material Subcontractor?
2. Submit a list of Subcontractors to the MassHealth Contract Management Team.
3. What is the type of service to be provided by the Subcontractor (e.g., Pharmacy Benefit Manager (PBM), Behavioral Health, Dental, Vision, Transportation, claims processing, care management, mail order pharmacy, etc.)?
4. What is the scope of the service to be provided by the Subcontractor (e.g., PBM, Behavioral Health, Dental, Vision, Transportation, claims processing, care management, mail order pharmacy, etc.)?
5. What are the primary services that this Subcontractor will perform, including the business functions, and/or the range of health conditions on which this Subcontractor will focus?
6. What specific services will the Subcontractor provide? If comparable services are to be provided by the SCO Plan, how will the services provided by this Subcontractor differ from those provided by the SCO Plan and why are such redundancies necessary?
7. What is the expected effective date of the Subcontract?
8. What is the expected date on which the Subcontractor will begin to deliver services, if different from the expected effective date of the Subcontract (due to ramp up time or

other implementation factors)?

9. What are the key reasons for choosing to contract with Subcontractor to perform these activities?

10. What are the key reasons for selection of this Subcontractor?

11. Confirm that the SCO Plan has ensured and explain how the SCO Plan has ensured that the Subcontractor is financially sound.

SUBCONTRACTOR REIMBURSEMENT

12. How will the Subcontractor be reimbursed? If reimbursement is on a PMPM, will the reimbursement be based on enrollees referred or enrollees served? If based on enrollees served, please provide a definition of "served" in this respect.

13. Provide a summary of the ROI review conducted to justify the anticipated gains and potential cost savings as an offset to the increased administrative expenditure.

SCO PLAN STAFF TRAINING AND COORDINATION

14. How and when will SCO Plan Enrollee Services and all other SCO Plan business units' staff be trained about the Subcontractor?

15. Submit copies of the relevant training materials to MassHealth Contract Management Team.

16. Will the SCO Plan designate staff to interact with the Subcontractor? If so, which staff and how many will be designated? Will interactions between staff and the Subcontractor take place in-person or remotely or both?

17. Specify the nature of coordination and communication that will occur between the Subcontractor and SCO Plan staff.

18. Describe the nature of communication and coordination, and transfer of information, between this Subcontractor and other Subcontractors, as applicable, for each of the above listed interactions. Include the role of the SCO Plan for each.

NOTIFICATION OF AND EFFECTS ON ENROLLEES (IF APPLICABLE)

19. How many Enrollees in total will the Subcontractor serve? How will Enrollees be identified for this service?

20. Will the Subcontractor operations be visible or transparent to Enrollees?

21. How and when will existing Enrollees be notified of the role and availability of the Subcontractor?

SUBMIT DRAFT COPIES OF THE RELEVANT NOTIFICATION

LETTERS/MATERIALS

22. Will new Enrollee identification cards be sent? If so, how and when?

23. Identify any differences in access to Enrollee services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Enrollees.

24. Describe any other anticipated effects of the Subcontractor's on Enrollees' engagement with the SCO Plan.

NOTIFICATION OF AND EFFECTS ON PROVIDERS (IF APPLICABLE)

25. Will the Subcontractor operations be visible or transparent to Providers?

26. How and when will the MCE provider network be informed about the Subcontractor?

PLEASE SUBMIT DRAFT COPIES OF THE RELEVANT NOTIFICATION AND TRAINING MATERIALS

27. How will the MCE ensure that PCPs are aware and approving of any information that the Subcontractor presents to Enrollees?

28. Identify any differences in access to Provider services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Providers.

29. Describe any other anticipated effects of the Subcontractor on Providers.

SYSTEMS/ DATA

30. Will the Subcontractor have retrospective or live access to any SCO Plan systems? If so, which system(s)?

31. Describe data elements to be shared between the Subcontractor and the SCO Plan.

32. Describe the process for data sharing between the Subcontractor and the SCO Plan.

33. How will data generated by the Subcontractor be integrated into SCO Plan system(s), if applicable? How will data in the SCO Plan system be transferred to the Subcontractor, if applicable? What will be the frequency of such integration? How will data integrity be ensured? Explain the arrangement that will ensure the Enrollee has the full range of recourse via the grievance and appeal system, including timely notifications and resolutions of processes.

34. Describe any expected loss of data history due to implementation of the Subcontract, if any.

35. Describe how the SCO Plan will manage any unanticipated loss of data/information due

to implementation of the Subcontract.

36. Does the SCO Plan intend to operate redundant IT systems before a new system is relied upon solely? If so, for how long and how will the SCO Plan manage such redundancy of systems?

37. Describe the process that will be used to ensure that the IT system will have capacity to interface with New MMIS effectively, as applicable.

READINESS REVIEW

38. Describe the readiness review that the SCO Plan will conduct of the Subcontractor, including timeframes.

39. Provide the SCO Plan's contingency plan should the Subcontractor not be ready to operate by the expected implementation date. At what point will this contingency plan be implemented?

40. Has the Subcontractor worked with MassHealth or other Medicaid populations and/or within the MA market? If so, address prior experiences and measures of performance, including results of services implemented, if known.

41. Describe the training and education that the SCO Plan will provide to the Subcontractor regarding the SCO Plan and the MassHealth population.

EVALUATION

42. Describe how the Subcontractor's performance will be evaluated. Does the SCO Plan to evaluate the Subcontractor, or will the Subcontractor conduct the evaluation independently? If the Subcontractor will self-evaluate, what role, if any, will the SCO Plan play in the evaluation?

43. How will the SCO Plan ensure effective Subcontractor participation in all EQRO related activities?

44. How will the SCO Plan ensure the Subcontractor's compliance with all MassHealth MCE Program contractual provisions, including those relating to confidentiality of information and Marketing?

45. Reference any national, state, and/or local standards to which the Subcontractor will adhere.

46. How will the SCO Plan ensure that all Subcontractors and entities associated with the Subcontractor are developing, monitoring, and tracking all excluded entity reporting requirements?

SECTION 2

Please answer all questions completely within the area below that are applicable to the new Subcontractor type.

BEHAVIORAL HEALTH SUBCONTRACTOR:

1. What are the SCO Plan's reasons for deciding to subcontract for some or all of its behavioral health operations?

2. Describe the SCO Plan's planned management structure of the behavioral health carve-out vendor.

3. How will the behavioral health material subcontract support the integration of physical and behavioral medical care management? How will care management be structured for enrollees with both medical and behavioral health issues that require care management?

PBM:

What are the SCO Plan's key reasons for selecting this PBM, or switching from the current PBM?

DENTAL SUBCONTRACTOR:

1. What are the SCO Plan's reasons for deciding to subcontract for some or all of its dental operations?

2. Describe the SCO Plan's planned management structure of the dental third-party administrator.

3. How will the dental material subcontract support the integration of physical and oral health management? How will care management be structured for enrollees with both medical and oral health issues that require care management?

VISION SUBCONTRACTOR:

1. What are the SCO Plan's reasons for deciding to subcontract for some or all of its vision operations?

2. Describe the SCO Plan's planned management structure of the vision third-party administrator.

3. How will the vision material subcontract support the integration of physical and vision management? How will care management be structured for enrollees with both medical and visual impairments that require care management?

TRANSPORTATION SUBCONTRACTOR:

1. What are the SCO Plan's reasons for deciding to subcontract for some or all of its

transportation operations?

2. Describe the SCO Plan's planned management structure of the transportation vendor.

3. How will the transportation material subcontract support the plans' independent living principles? How will care management be structured for enrollees with both medical and non-medical issues that require transportation services?

MAIL ORDER PHARMACY:

1. What are the key reasons for proposing a Mail Order Pharmacy (MOP) program?

2. Provide an overview and description of the proposed MOP program.

3. Provide a list of the therapeutic drug categories and covered drugs that will be included and excluded in the MOP program, along with a description of the inclusion/exclusion criteria. Describe the process that will be used to monitor and mitigate inappropriate early refills. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

4. Describe the process that will be used to minimize the risk of drug diversion. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

5. Describe the process that will be used to provide emergency access (i.e. weekends, after hours, vacation, etc.) if an enrollee does not receive the prescription drug in a timely manner. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

6. Describe the process that will be used to ensure that enrollees are fully informed and provided an opportunity to raise questions and concerns regarding the risks and side effects of the drugs received through the MOP Program. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

7. Describe the process that will be used to ensure that an enrollee will not be denied medications as a result of not paying a copayment. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

CARE MANAGEMENT:

1. Describe the process that will be used to transfer the active caseloads of enrollees currently receiving Care Management from the SCO Plan and/or other Subcontractor to

the new Subcontractor.

2. Describe the process that will be used to ensure minimal disruption to enrollees and/or care management systems. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

3. Describe the process that will be used to ensure effective communication and coordination between the Subcontractor, PCPs of enrollees in care management, and the SCO Plan. What are the respective roles of the Subcontractor and the SCO Plan in this process, and the nature of communication and collaboration between the Subcontractor and the SCO Plan in this process?

UTILIZATION MANAGEMENT

Describe the mechanisms it will use to ensure that subcontractor managed levels of service utilization are appropriate and simultaneously ensure high quality care in a manner that would not impede access to medically necessary care.

CLAIMS:

1. Describe the process that will be used to transfer the current claims processing system to the new claims processing system.

2. Describe the process that will be used to ensure minimal disruption to claims processing and other IT functions, including timely and appropriate payment of claims. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

3. Describe the process that will be used to ensure that any prior approvals granted under the current system will be honored under the Subcontractor.

4. Describe the process that will be used to ensure that claims will not be double-paid by the current and the new Subcontractor during transition. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

5. Explain what steps will be taken to be sure the new claims system can properly perform all the interfaces with MMIS that are required.

6. Describe steps to ensure MassHealth reporting will not be negatively impacted.

CALL CENTER

1. Describe the process for handling various types of calls from MassHealth enrollees.

2. Is a separate entity responsible for handing calls for MassHealth Enrollees, prospective

enrollees, and/or enrollees in other product lines? If so, what is the nature of referral and coordination between the Subcontractor(s) and MCE?

3. Please describe how the process for handling various types of calls differs for MassHealth enrollees, prospective enrollees, and/or enrollees in other product lines, if applicable.

4. How will the MCE ensure that all required enrollee notifications occur in a timely and effective manner?

   Other Comments:

APPENDIX L
SCO QUALITY IMPROVEMENT AND PROJECT REQUIREMENTS

This Appendix details how EOHHS will assess quality performance and calculate the Quality Withhold Payment amount for a SCO Contractor as described in **Section 4.7.2**. EOHHS reserves the right to modify the methodology set forth herein prior to execution of the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. EOHHS anticipates ongoing evaluation of this methodology, including but not limited to the list of Quality Measures, during the Contract Term. EOHHS anticipates engaging the Contractor as well as other stakeholders in this evaluation process. The following information is included:

1. Overview of SCO Quality and Accountability

2. Performance Assessment Methodology

2.1 Measure Scoring Methodology

2.2 Quality Payment

2.3 Methodology for Establishing Performance Benchmarks for Quality Measures

2.4 Quality Withhold Payment Amount Adjustments

3. Overview of SCO Quality and Accountability

The Contractor shall have the opportunity to earn a Quality Withhold Payment for each Contract Year. The Contractor's Quality Withhold Payment amount shall be calculated as described in this Appendix and as further specified by EOHHS.

EOHHS has established a slate of SCO Quality Measures (see **Figure 4.7-1** in **Section 4.7.2)**. The Contractor's Quality Withhold Payment amount will be determined by the Contractor's performance on the Quality Measures against benchmarks set by EOHHS (achievement points, as described in **Section 2.1.A** below), as well as any improvement in the Contractor's Quality Measure performance compared to prior Contract Year(s), if applicable (improvement points, as described **Section 2.1.B** below).

EOHHS, at its discretion, may also implement opportunities to earn additional points added to the overall scoring methodology.

If the Contractor is unable to meet minimum requirements sufficient to formally report at least three of the quality withhold measures listed in **Figure 4.7-1** for a given year due to low enrollment or inability to meet other measurement criteria, EOHHS shall return the amount withheld for the quality withhold payment. The payment shall be contingent upon the Contractor completing and submitting the HEDIS IDSS file to EOHHS.

4. Performance Assessment Methodology

4.1 Measure Scoring Methodology

The Contractor will be assigned achievement and improvement points based on its performance on each Quality Measure.

A. Achievement Points

The Contractor may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

1. EOHHS will establish an “attainment threshold” and a “goal benchmark” for each Quality Measure:

    a. “Attainment threshold” sets the minimum level of performance at which the contractor can earn achievement points.

    b. “Goal benchmark” is a high-performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points).

2. EOHHS will calculate the Contractor’s performance score on the Quality Measure based on the measure specifications.

3. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:

    a. If the Contractor’s performance score is less than the attainment threshold: 0 achievement points.

    b. If the Contractor’s performance score is greater than or equal to the goal benchmark: 10 achievement points.

    c. If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:

        i. 10*((Performance Score – Attainment Threshold) / (Goal Benchmark – Attainment Threshold))

EXHIBIT 1 – Example Calculation of Achievement Points for Measure A

Measure A attainment threshold = 45% **Measure A goal benchmark** = 80%

Example Calculation of Achievement Points for Measure A		
	Measure A Performance Score	**Achievement Points Earned**
Scenario 1	25%	0
Scenario 2	90%	10
Scenario 3	58%	3.7*

**Achievement points earned = 10*((58% - 45%) / (80% - 45%)) = 3.7 points*

B. Improvement Points

In addition to receiving achievement points based on performance (on a 0 to 10 scale), the Contractor may earn improvement points for reaching established improvement targets for each Quality Measure starting in Contract Year 2. Improvement points will be calculated as follows:

1. EOHHS will calculate the Contractor's performance score on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

2. EOHHS will compare the Contractor's performance score on each Quality Measure to the Contractor's performance score on that same Quality Measure from the highest scoring previous Contract Year.

3. EOHHS will calculate an Improvement Target for each Quality Measure using the following formula (unless otherwise specified by EOHHS). The Improvement Target is based on at least a 10% improvement each year in the gap between Goal Benchmark and the Attainment Threshold of each SCO measure.

    a. Improvement Target formula = [(Goal Benchmark –Attainment Threshold) /5]

i. *For example, for Measure A, if the Attainment Threshold is 50% and the Goal Benchmark is 60%, the Improvement Target is 1 percentage points [(60 – 50)/10)].*

b. For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

i. *For example, for Measure B, if the Attainment Threshold is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 1.02 percentage points [(90.2 – 80)/10)] which rounds to 1.0 percentage points.*

c. The Contractor may earn up to five (5) improvement points for increases in measure score which meet or exceed the improvement target.

i. *For example, for Measure B, the Improvement Target is 2.0 percentage points. If Contractor's performance in Contract Year 4 is 54.0% and the Contractor's performance in Contract Year 5 is 60.0%, the Contractor improvement from Contract Year 4 to Contract Year 5 is 6.0 percentage points [(60.0-54.0)] and the Contractor is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.*

d. For the purposes of calculating the difference in Contractor quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

i. *For example, for Measure B, if Contractor performance in Contract Year 4 is 54.54% and if Contractor performance in Contract Year 5 is 60.17%, the Contractor improvement from Contract Year 4 to Contract Year 5 is 5.63 percentage points [(60.17-54.54)], and the Contractor improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6 percentage points.*

e. The Improvement Target is based on the *higher* of the original baseline or any year's performance prior to the current Contract Year. This is intended to avoid rewarding regression in performance.

i. *For example, for Measure B, assume Contractor performance in Contract Year 1 is 90.0% and the Improvement Target is 2.0 percentage points. If in Contract Year 4 the performance for the Contractor decreases to 89.0%, in Contract Year 5 the Contractor would need to reach 92.0% to reach the Improvement Target.*

f. There are several special circumstances:

i. *At or Above Goal:* If the Contractor has prior Contract Year performance scores equal to or greater than the Goal

Benchmark then the Contractor may still earn up to five (5) improvement points in each Contract Year if improvement from the highest prior Contract Year is greater than or equal to the Improvement Target.

g. *At or Below Attainment:* If the Contractor has prior Contract Year performance scores less than the Attainment Threshold then the Contractor may still earn up to five (5) improvement points each Contract Year if improvement from the highest prior Contract Year is greater than or equal to the Improvement Target, and performance in the current Contract Year does not equal or exceed the Attainment Threshold. Additionally, if the Contractor has prior Contract Year performance scores less than the Attainment Threshold and current Contract Year performance scores are equal to or above the Attainment Threshold then the Contractor may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

EXHIBIT 2 – Example Calculation of Improvement Points for Measure B

Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	Contract Year 4 Score	Contract Year 5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1 points	Yes	5
Scenario 2:	50.0%	56.7%	6.7 points	Yes	5
Scenario 3:	59.5%	63.0%	3.5 points	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0 points	Yes; below Attainment Threshold	5
Scenario 5:	46.0%	49.0%	3.0 points	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0 points	No	0

4.2 Quality Payment

The Contractor shall receive Quality Withhold Payments as described in **Section 4.7.2** of the Contract. The methodology for calculating the Contractor's Quality Withhold Payment amount shall be as follows, or as further specified by EOHHS:

a. The Quality Withhold amounts are specified in **Section 4.7.2** of the Contract for each Contract Year. EOHHS may further increase the quality withhold in Contract Years 2, 3, 4, and 5, by no more than a 0.25% increase over the prior Contract Year.
b. EOHHS will sum the Contractor's achievement and improvement points for all Quality Withhold Measures. Once the total number of points has been calculated, EOHHS will divide the sum by the maximum number of achievement points for which the Contractor is eligible resulting in a value between zero (0) and one (1)

expressed as a percentage (i.e., 0% to 100%).

c. To determine the Quality Withhold Payment amount, the Quality Withhold Amount (2.2.a of this Appendix) will be multiplied by the quality performance percentage (2.2.b of this Appendix).

EXHIBIT 3 – Example Calculation of Quality Withhold Payment Amount

Example Calculations of Quality Withhold Payment Amount		
Example 1	Two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points	
	Total improvement points: 0 + 5 = 5 points	
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points	
	Quality performance percentage = 6.5/20 * 100 = 32.5%	
	Quality Withhold Payment amount = .325 x Quality Withhold amount.	

i. *In the above example, a SCO plan will earn 32.5% of the total Quality Withhold amount available to them.*

5. Methodology for Establishing Performance Benchmarks for Quality Measures

EOHHS will establish the attainment threshold and goal benchmark for each Quality Measure utilizing historical MassHealth data and where applicable regional or national

data.

- For Quality Measures based on NCQA HEDIS measures, EOHHS anticipates using NCQA Quality Compass percentiles, as well as MassHealth historical SCO performance.
- For non-HEDIS Quality Measures, EOHHS anticipates using MassHealth historical SCO performance.
- For other Quality Measures where EOHHS does not have access to applicable data, EOHHS anticipates using MassHealth benchmarks based on SCO attributed populations.

6. Quality Withhold Payment Amount Adjustments

EOHHS may, in its discretion, establish a process through which the Contractor may seek clarification on or request revisions to its Quality Withhold Payment amount. If the Contractor chooses to seek clarification on or requests revisions to its Quality Withhold Payment amount, the Contractor shall follow processes established by EOHHS, including meeting specified deadlines and providing all information requested by EOHHS. EOHHS does not guarantee any adjustments to the Quality Withhold Payment amount.

The Contractor shall identify a key contact, responsible for raising such issues to EOHHS or its designee and working with the appropriate personnel to discuss and resolve issues as appropriate.

APPENDIX M
SCO DISCRETIONARY INVOLUNTARY DISENROLLMENT REQUESTS FOR DISRUPTIVE CONDUCT

EOHHS shall decide whether to approve or deny each request for involuntary disenrollment based on an assessment of the particular facts associated with each request, including an assessment of whether the Contractor followed all of the necessary procedural and Enrollee notice requirements.

The following requirements shall be met for all requests from the Contractor for Discretionary Involuntary Disenrollment due to disruptive conduct, as described in **Section 2.4.12.4.2**. A plan may disenroll an Enrollee whose behavior is disruptive only after EOHHS has reviewed and approved the request.

An Enrollee is disruptive if their behavior substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

A. Procedural requirements:

1. The Contractor shall make a serious effort to resolve the problems presented by the Enrollee, including providing reasonable accommodations. In addition, the Contractor shall inform the Enrollee, or their representative, of the right to use the Plan's grievance procedures. The Enrollee has a right to submit any information or explanation that the Enrollee may wish to the Contractor.

2. The Contractor shall document the Enrollee's behavior. The Contractor may request from EOHHS the ability to decline future enrollment by the individual into the Contractor's SCO Plan. The Contractor shall submit this information and any documentation received by the beneficiary to EOHHS.

3. The Contractor's request to involuntarily disenroll an Enrollee for disruptive conduct shall be in writing and include all available supporting documentation, including the following:

    a. Documentation of the disruptive behavior, including dates, locations, and actions;

    b. Information about the Enrollee, including age, diagnosis, mental status, Functional Status, a description of their social support systems, and any other relevant information;

    c. The plan's own efforts to resolve any problems, and any extenuating circumstances;

    d. Statements from providers describing their experiences with the Enrollee (or

refusal to provide such statements); and

e. Any information provided by the Enrollee. The Enrollee can provide any information they wish.

f. If the Contractor is requesting the ability to decline future enrollments for this individual, the Contractor shall include this request explicitly in the submission.

4. Prior to approval, the complete request shall be reviewed by EOHHS, including by EOHHS staff with appropriate clinical or medical expertise:

B. Evidentiary standards

5. At a minimum, the supporting documentation shall demonstrate the following to the satisfaction of EOHHS staff with appropriate clinical or medical expertise:

g. The Enrollee is presently engaging in a pattern of disruptive conduct that is substantially impairing the Contractor's ability to arrange for or provide Covered Services to the Enrollee and/or other Enrollees.

h. The Contractor made serious efforts to address the disruptive conduct including at a minimum:

i. A documented effort to address the Enrollee's underlying interests and needs reflected in their disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act, including those for individuals with mental and developmental disabilities. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. EOHHS will determine whether the reasonable accommodations offered are sufficient.

ii. A documented provision of information to the Enrollee of their right to use the Contractor Grievance procedures.

6. The Contractor provided the Enrollee with a reasonable opportunity to cease their disruptive conduct.

7. The Contractor complied with all Enrollee notice requirements, as described in Section D of this Appendix.

8. The Contractor shall provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of Covered Services.

9. The Contractor shall provide evidence that the Enrollee's continued Enrollment in the Plan substantially impairs the Contractor's ability to provide or arrange for Covered Services, to either this particular Enrollee or other Enrollees. This substantial impairment may be demonstrated by treating providers explicitly

documenting their belief that there are no reasonable accommodations the Contractor or provider could provide that would address the disruptive conduct.

10. The Contractor may also provide evidence of other extenuating circumstances.

C. Limitations

11. The Contractor shall not seek to disenroll an Enrollee because of any of the following:

    i. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless the Contractor has demonstrated that the Enrollee's continued Enrollment in the Plan substantially impairs the Contractor's ability to provide or arrange for Covered Services, to either this particular Enrollee or other Enrollees.

    j. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

    k. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Services.

    l. The Enrollee's mental capacity is, has, or may become diminished.

D. Review Process

12. Once EOHHS reviews the request, it may either (1) disapprove or (2) approve the request. EOHHS will make the decision within 20 business days after receipt of all the information required to complete its review.

13. Should the request be approved, the disenrollment is effective the first day of the calendar month after the month in which the Contractor gives the Enrollee a written notice of the disenrollment.

14. If the request for involuntary disenrollment for disruptive behavior is approved:

    m. EOHHS may require the Contractor to provide reasonable accommodations to the individual in such exceptional circumstances that EOHHS deems necessary.

    n. The Contractor may request that EOHHS consider prohibiting re-enrollment in the Contractor's plan. If this is not requested, and the individual is disenrolled due to disruptive behavior, the individual may re-enroll into the Contractor's plan in the future.

E. Notices

15. The disenrollment for disruptive behavior process requires 3 written notices:

    o. **Advance notice** to inform the Enrollee that the consequences of continued disruptive behavior may be disenrollment;

    p. **Notice of intent** to request EOHHS's permission to disenroll the Enrollee; and

    q. **A planned action** notice advising that EOHHS has approved the Contractor's request.

16. Requirements

    The Contractor shall customize each notice following the requirements outlined in this section.

    r. Advance Notice

        iii. Prior to forwarding an involuntary disenrollment request to EOHHS, the Contractor shall provide the Enrollee with a written notice describing the behavior it has identified as disruptive and how it has impacted the Contractor's ability to arrange for or provide services to the Enrollee or to other Enrollees of the plan. The notice shall do the following:

            (a) Make clear that the Enrollee's current plan coverage is still in effect.

            (b) Explain that the Enrollee's continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action.

            (c) Provide information about who the Enrollee may contact for more information or to ask questions about the notice.

            (d) Advise the Enrollee of their right to use the Contractor's, and EOHHS's if appropriate, grievance procedures and to submit any information or explanation.

        iv. Process:

            (e) The Advance Notice shall not include a projected effective date of disenrollment.

            (f) The Contractor shall include a copy of this notice and the date it was provided to the Enrollee in any information forwarded to EOHHS.

            (g) If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor shall begin the process again if it still seeks involuntary disenrollment of the Enrollee. This includes

sending another advance notice.

s. Notice of Intent

v. If the Enrollee's disruptive behavior continues despite the Contractor's efforts, the Contractor shall notify the Enrollee of its intent to request EOHHS's permission to disenroll them for disruptive behavior. This notice shall do the following:

(h) Make clear that the Enrollee's current plan coverage is still in effect.

(i) Notify the Enrollee of the Contractor's intent to request EOHHS's permission to dis-enroll them for disruptive behavior.

(j) Provide information about who the Enrollee may contact for more information or to ask questions about the notice.

(k) Advise the Enrollee of their right to use the Contractor's, and EOHHS's if appropriate, grievance procedures and to submit any information or explanation.

vi. Process:

(l) The Notice of Intent shall not include a projected effective date of disenrollment.

(m) The Contractor shall include a copy of this notice and the date it was provided to the Enrollee and forward this documentation to EOHHS.

t. Planned Action Notice

vii. If EOHHS approves the request to disenroll the Enrollee for disruptive behavior, the Contractor shall provide the Enrollee with a written notice that contains the following:

(n) A statement that this action was approved by EOHHS and meets the requirements for disenrollment due to disruptive behavior described above.

(o) Information about who the Enrollee may contact for more information or to ask questions about the notice.

(p) Advise the Enrollee of their right to use the Contractor's, and EOHHS's if appropriate, grievance procedures and to submit any information or explanation.

viii. The Contractor shall submit the disenrollment transaction to EOHHS and to CMS only after providing the notice of disenrollment (Planned Action

Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the Contractor gives the Enrollee a written notice of the disenrollment.

ix. If EOHHS does not approve the request to disenroll, the Contractor shall provide the Enrollee with a written notice, notifying them of that decision. If the Contractor wishes to pursue another involuntary disenrollment request for the same Enrollee, the Contractor shall begin the process again. This includes sending another Advance Notice.

APPENDIX N
SCO ENROLLEE RIGHTS

The Contractor must have written policies regarding the Enrollee rights specified in this Appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes into consideration cultural considerations, Functional Status, and language needs. The Contractor must comply with any applicable federal and State laws that pertain to Enrollee rights. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100 and 42 C.F.R. § 422 Subpart C. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.

B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

D. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition, Functional Status, and language needs.

E. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, gender identity, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.

F. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

G. Access to an adequate network of primary and specialty providers who are appropriately qualified and capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting, as well as access to an ongoing source of primary care.

H. The right to receive a second opinion on a medical procedure and have the Contractor pay for the second opinion consultation visit.

I. The right to choose a plan and provider at any time.

J. The right to request a change of Care Coordinators.

K. The right to have a voice in the governance and operation of the health plan, as detailed in this Contract.

L. The right to be furnished Covered Services in accordance with this Contract.

M. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility and a right to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:

a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordinating Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.

b. Receive complete and accurate information on his or her health and Functional Status from the interdisciplinary team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration the Enrollee's Functional Status, and language and cultural needs. An Enrollee who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible to the Enrollee or Enrollee's representative. Information must be available:

    i. Before enrollment.

    ii. At enrollment.

    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.

e. Have Advance Directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.

f. Receive reasonable advance notice, in writing, of any transfer to another

treatment setting and the justification for the transfer.

g. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

h. Be provided with complete documentation from the Contractor upon request to support any appeals or grievance actions

N. The right to receive medical and nonmedical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.

O. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

P. The right to freely exercise his or her rights, and to be assured that exercising those rights will not adversely affect the way the Contractor and its providers or the State Agency treat the Enrollee.

Q. The right to receive the information required pursuant to the Contract.

R. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 42 C.F.R. § 438.10(g).

S. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.

APPENDIX O
SCO CONTRACTOR INFORMATION

Contractor Legal Name: Commonwealth Care Alliance, Inc.

Contractor Principal Office(s) Address: 30 Winter Street, Boston, MA 02108

Contractor Recipient of Written Notices:

Office of the CEO
Commonwealth Care Alliance, Inc.
30 Winter Street
Boston, MA 02108

APPENDIX P
SCO DENTAL ACCESS

EOHHS is providing this appendix based on current information. EOHHS will update this appendix as appropriate.

EXHIBIT 1 – Access Point

An “Access Point” is a physical site where one or more MassHealth Dental Providers provide services to MassHealth Members. Access Points by specialty are as follows:

MassHealth Dental Provider Types	Current Access Points	99% of Current Access Points (Rounded up to nearest whole number)
General Dentist	6,908	6,839
Oral Surgeon	374	371
Grand Total	**8,804**	**8,716**

EXHIBIT 2 – Access Standards

"Access Standards" are the average (over each Contract Year) minimum aggregate ratios of certain types of MassHealth Dental Providers to MassHealth Members, as follows:

MassHealth Dental Provider Type	Provider to Member Ratio
General Dentist	1: 1,500
Oral Surgeon	1: 20,000

EXHIBIT 3 – Travel Times

"Travel Times" are the average (over each Contract Year) minimum percentage of MassHealth Members with access to certain types of MassHealth Dental Providers, as follows:

MassHealth Dental Provider Type	Percentage of Members with Access
General Dentist	95% of Members have access to 2 General Dentists within 10 minutes of their home
Oral Surgeon	95% have access to 1 Oral Surgeon within 30 minutes of their home

EXHIBIT 4 – Wait Times

"Wait Times" are the average (over each Contract Year) minimum percentage of MassHealth Members with access to appointments within wait-time maximums defined as the time between when a MassHealth Member attempts to make an appointment and when they are seen by a Dental Provider, stratified by specified appointment types as follows below:

Appointment Type	Percentage of Members within Wait-time Maximums
Urgent dental care	95% of Members have access to urgent care appointments within 48 hours, including appointments with specialists for urgent care
Routine dental care	95% of Members have access to routine care appointments within 30 days
Non-emergency dental specialist care	95% of Members have access to non-emergency specialist appointments within 60 days

APPENDIX Q
SCO POPS BATCH INTERFACES

All Interfaces from, or to, a Senior Care Options (SCO) Plan and POPS have been defined as batch interfaces (as opposed to transactional).

The POPS Portal is the appropriate Channel for uploading Claim files and PBM Network Files. Additionally, this portal is where SCO Control Reports, SCO Error spreadsheets, and SCO Rejected Claim files are available for pickup.

All Claim files will be submitted in the formats and on the schedule as provided by EOHHS which may be customized by EOHHS from time to time with prior written notice to SCOs.

Current Formats are as follows:

1. Attachment A - MCE Pharmacy Claims Level Interface 7.1.2019 (NCPDP Post-Adjudication Standard Version 2.1. – History View) and MCE Pharmacy Claims Level Interface Change Control Doc Ver 2 7.1.2019.

2. MCE Pharmacy Provider Network Identification Layout

   Any SCO drug claims and reversals submitted that are rejected by EOHHS due to an unknown pharmacy provider, the SCO is required to complete and submit the SCO Pharmacy Provider Network layout 3 days prior to the submission of the SCO Error Correction files.

3. MassHealth Drug Rebate File Submission Report for SCO Pharmacy Claims

   This report documents file submission requirements and due dates for the inclusion of SCO Pharmacy claims in the Massachusetts Medicaid invoicing for federal drug rebate.

4. Change in BIN/PCN/Group Number Report

   This ad-hoc report is delivered whenever there is a change in BIN/PCN/Group Number for the PBM submitting claims for inclusion in the Massachusetts Medicaid invoicing of federal drug rebates.

Schedule for Interfaces:

The SCO claims files must be uploaded to the POPS secure portal **within 5 calendar days** following the close of the prior month.

Any SCO Retail Pharmacy drug claims and reversals submitted that are rejected by EOHHS must be corrected and resubmitted in the SCO Error Correction file **at least 1 day** prior to the next month's SCO drug claim file submission.

Listed below is a short description of each of the interfaces from, or to, POPS and the SCOs. Note that the terms INBOUND and OUTBOUND are used to denote the flow of data relative to POPS. Inbound is data coming from a SCO to POPS, and outbound is data coming from POPS to a SCO.

A. Inbound Interfaces

1. SCO Claims Files to EOHHS

   On a monthly basis, the Contractor shall transmit the Inbound SCO Retail Pharmacy Claims Level file to the Distribution/ MASS PBM/ (SCO Name)/ ToMassHealth/ folder to the POPS portal **within 5 calendar days** following the close of the prior month.

   SCO Retail pharmacy claims and/or reversals submitted that are rejected by EOHHS must be corrected using the SCO Error Correction File format and transmitted to the Distribution/ MASS PBM/ (SCO Name)/ ToMassHealth/ **at least 1 day prior to** the next month's SCO drug claim file submission

2. SCO Provider File or their contracted PBMs Network file to EOHHS

   Any SCO drug claims and/or reversals submitted that are rejected by EOHHS due to an unknown pharmacy provider must be corrected using the SCO Provider Network layout and transmit to the Distribution/ MASS PBM/ (SCO Name)/ ToMassHealth/ folder on the POPS portal **3 days prior** to the submission of the Error Correction files.

B. Outbound Interfaces

Error Correction Files to SCO from EOHHS

Any SCO Retail drug claims and reversals submitted that are rejected by EOHHS will be available for pickup via the POPS portal for three calendar days after e-mail notification to the SCO submitter containing a SCO Control Report, SCO Error Spreadsheet, and SCO Rejected Claim file on the Distribution/ MASS PBM/ (SCO Name)/ FromMassHealth/ folder within the POPS portal."

APPENDIX R
SCO ACCEPTABLE ADMITTED ASSETS

1.	Bonds
2.	Preferred Stocks (Stocks)
3.	Common Stocks (Stocks)
4.	First Liens – Mortgage loans on real estate
5.	Other than First Liens – Mortgage loans on real estate
6.	Properties occupied by the company (less $0 encumbrances) (real estate)
7.	Properties held for the production of income (less $0 encumbrances) (real estate)
8.	Properties held for sale (less $0 encumbrances) (real estate)
9.	Cash, short-term investments, and cash equivalents
10.	Contract loans (including $0 premium notes)
11.	Other invested assets
12.	Receivables for securities
13.	Securities lending reinvested collateral assets
14.	Aggregate write-ins for invested assets
15.	Subtotal of the assets listed above
16.	Other, as approved by EOHHS

APPENDIX S
SCO FRAIL ELDER WAIVER

Appendix S is the application for a §1915 (c) HCBS Waiver hereafter referred to as the Frail Elder Waiver, and is incorporated by reference herein. The term "Frail Elder Waiver" as used in this Contract shall refer to the most recent CMS-approved Frail Elder Waiver application document, as it may be amended from time to time.

EOHHS shall provide to the Contractor any future CMS-approved amendments to the Frail Elder Waiver outside of this Contract. Each CMS-approved amendment to the Frail Elder Waiver does not require an amendment to this Contract's **Appendix S**.

Nevertheless, the Contractor is responsible for referring to the most updated CMS-approved version of the Frail Elder Waiver and complying with its requirements. For reference, CMS lists approved applications online at:

https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82036

As of the Contract Effective Date, the current document is the Frail Elder Waiver approved by CMS and effective March 29, 2024.

APPENDIX T
SCO MDS-HC 2.0 SUPPLEMENTAL INSTRUCTIONS

Section 2.5.5 of the SCO Contract require the Minimum Data Set – Home Care (MDS-HC) assessment to be completed by a Registered Nurse (RN) and submitted electronically to the Executive Office of Health and Human Services (EOHHS). Completion of the MDS-HC accomplishes two key objectives. First, it establishes the correct Rating Category for SCO Enrollees as Nursing Home Certifiable (NHC), Community Behavioral Health (CBH), or Community Other in the Medicaid managed care payment system. Second, it serves as a core component of the member's Health Risk Assessment (HRA) and a basis for the member's individualized care plan.

The Plan must ensure that documentation in the MDS-HC and Request for Services (RFS) document is accurate and up to date. When the Plan determines that the member has improved, declined, or has had any other significant change in their condition, the Plan must submit an updated MDS-HC to reflect the change in the member's clinical status. In addition, member individualized care plans and documentation in the member's plan file must support the member's need for care, as documented in and aligned with the MDS-HC. Upon request by MassHealth, the Plan must be able to produce documentation that demonstrates the member's specific skilled need(s) and/or activity of daily living needs.

A member's individualized care plan must at a minimum include specific assessments, goals, interventions, who is providing the service, and their frequency. This specifically includes documenting, in the care plan, when informal support, such as relatives living in the home, are providing care to meet a member's skilled and/or ADL need(s). The care plan must specify whether a skilled service is being provided by a registered nurse, therapist or other caregiver. When a skilled need is being provided by a caregiver, the frequency and nature of the supervision provided by the registered nurse or therapist overseeing the delivery of the skilled services must be documented in the care plan. The care plan shall also document if any skill training has been provided to the caregiver.

Under **Section 4.3.2** of the SCO Contract, MassHealth has the right to audit Plans for their adherence to the guidance provided within this document. Where Plans fail to meet the requirements provided below, MassHealth may reallocate members to their appropriate rating category as well as issue financial sanctions.

Question 5 of the RFS must be completed for all MDS-HCs. For MDS-HC documents submitted on or after January 1, 2025, MassHealth will review Question 5 of the RFS to ensure that it documents which criteria specified in 130 CMR 456.409 the plan is relying upon to demonstrate NHC eligibility. Failure to document the specific daily skilled need under 130 CMR 456.409(A) (path 1); or failure to document the specific three needed services under 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C) (path 2), may result in

MassHealth reallocating the member to the Community Other rating category AND recouping the difference between the Community Other payment level and the NHC payment level, retroactive to the date of the MDS-HC submission.

A. NURSING HOME CERTIFIABLE (NHC):

For NHC, the information provided in the MDS-HC must establish that the member meets the state's nursing facility clinical eligibility criteria found in the MassHealth Nursing Facility Regulation 130 CMR 456.409.

130 CMR 456.409: Clinical Eligibility Criteria

To be assigned to the NHC rating category a member must be clinically eligible for nursing facility services. There are two paths to establish clinical eligibility for nursing facility services.

Path 1, the member must require one or more skilled services listed in 130 CMR 456.409(A) **daily**, or

Path 2, the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).

(A) Skilled Services (Path 1) – one skilled service daily (130 CMR 456.409(A))

Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding.

(2) nasogastric-tube, gastrostomy, or jejunostomy feeding.

(3) nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services.

- For SCO NHC, to rely on this subsection for skilled care, the nurse must document the specific tracheostomy care needed in the member's care plan.

(4) treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions).

(5) administration of oxygen on a regular and continuing basis when the

member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema)

(6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure).

(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety.

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection).

- For SCO NHC, Plans must be able to produce the documentation demonstrating the need for the urethral catheter upon request by MassHealth.

(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting.

- For SCO NHC, because these services require an institutional setting, plans cannot rely on (9) to demonstrate a skilled need for the NHC rating category determination.

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record).

- For SCO NHC, plans must be able to produce the physical therapy

notes upon request by MassHealth.

(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications.

(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

- For SCO NHC, Plans must be able to produce the therapy notes and physician or PCP documentation upon request by MassHealth.

(B) Assistance with Activities of Daily Living - (Path 2) 130 CMR 456.409(B)

Assistance with activities of daily living includes the following services:

(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;

(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;

(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;

(4) transfers when the member must be assisted or lifted to another position;

(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and

(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

- Activities of Daily Living (ADLs) must be documented accurately in the MDS-HC, RFS, and Member’s Care Plan and other supporting Documentation.

(C) Nursing Services. (Path2) - 130 CMR 456.409(C)

Nursing services, including any of the following procedures performed at least three

times a week, may be counted in the determination of medical eligibility under Path 2.

(1) any physician-ordered skilled service specified in 130 CMR 456.409(A).

- For SCO NHC, Plans must refer to **Section A** above and skilled service must occur at least three times a week.

(2) positioning while in bed or a chair as part of the written care plan.

(3) measurement of intake or output based on medical necessity.

- For SCO NHC, Plans must document the medical need for intake and output measurement in the member's care plan.

(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions.

(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional.

(6) physician- or PCP -ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals).

(7) physician- or PCP -ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention.

(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring.

- For SCO NHC, Plans must be able to produce the physician/PCP documentation upon request by MassHealth.

Data entered in the MDS-HC regarding skilled needs and skilled services must be clinically consistent and aligned with diagnoses listed in MDS-HC Section J.

For all initial or change-in-status MDS-HC submissions the skilled services may be in place at the time of assessment or must be in the process of being placed to meet those needs recorded in the MDS-HC. Services must be in place and documented in the care plan within 30 days. If, after 30 days, services are not in place, then the Plan must submit a new MDS-HC that accurately reflects the services that are in place.

In contrast, for MDS-HC submissions related to reassessments, the skilled services must be in place. The skilled need(s) must be being performed per 130 CMR 456.409 (A) daily (path 1), or the member must have a medical or mental condition requiring a combination of at least three services that are actually being provided from 130 CMR 456.409 (B) and (C), including at least one of the nursing services listed in (C) at least three times per week (Path 2). Support for the member's skilled need(s) must be documented in the member's care plan. If the member can fully and independently meet their skilled need(s), the member does not meet NHC level of care criteria.

B. COMMUNITY BEHAVIORAL HEALTH (CBH)

Information in the MDS-HC may not indicate NHC criteria as stated above and may indicate one or more actively treated behavioral health diagnoses that meet CBH rating category. Behavioral health diagnoses must be confirmed in the member's medical records and must be chronic and ongoing. ICD-10 coding must be accurate and documented in the MDS-HC.

C. COMMUNITY OTHER (CO)

Information in the MDS-HC may not indicate NHC criteria or CBH criteria as listed above. Those members will be included in the Community Other rating category.

D. REQUEST FOR SERVICES (RFS)

Question 5 on the RFS must be completed for all MDS-HCs submitted. MassHealth uses this field to understand which criteria specified in 130 CMR 456.409 the plan is relying upon to demonstrate NHC eligibility. Plans must document the specific daily skilled need under 130 CMR 456.409(A) (Path 1); or

document the specific three needed services under 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C) (Path 2).

- To access the drop-down free-text writing space for RFS Question 5, you must enter "YES" to question #5, regardless of whether or not a significant change in condition has (or has not) occurred.
- Question #5: *Has the member or applicant experienced a significant change in condition in the last 30 days?* Answer: "YES" and Text Box will become available. There is no other way to access the drop-down free-text writing field other than by entering 'YES" to question #5.
- Question #5 on the RFS must include any skilled nursing needs and/or ADLs documented in the MDS-HC.
    - Examples:
        1. A member is assessed on the MDS-HC to require physical assistance with bathing, and dressing, and requires daily assistance with administration of oral medications for monitoring of dosage, frequency, or adverse reactions.

a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires physical assistance with bathing (B1), dressing (B2), and oral medication management (C4).*

2. A member is assessed on the MDS-HC to require daily physical assistance with insulin injections.
    a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires daily physical assistance with subcutaneous injection (A1)."*
3. A member is assessed on the MDS-HC to require assistance with bathing, dressing, toileting, and transferring. They have a gastrostomy tube and require daily physical assistance with feeding.
    a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires physical assistance with bathing (B1), dressing (B2), toileting (B3), transferring (B4) and requires daily assistance with gastrostomy tube feedings (A2)."*
4. A member is assessed on the MDS-HC to have complicated heart failure with frequent decompensations and has a family caregiver who monitors heart rate, weight, blood pressure, and O2 sats on a daily basis with close skilled RN oversight.

- In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires monitoring of heart rate, weight, blood pressure, and O2 sats on a daily basis with close skilled RN oversight (A7) to ensure care is achieving its purpose."*
- Keep the information provided in Question #5 concise, clear, and specific.
- If the member is on the Frail Elder Waiver (FEW), please note "FEW" in Question 5.

E. ADDITIONAL AREAS REQUIRING SPECIAL ATTENTION FOR SCO SUBMISSIONS:

- Any MDS-HC assessment with a date 90 days prior or greater when submitted will not be accepted.
- All MDS's must be submitted by 2:00 pm on the last business day of the month. Submissions occurring after 2:00 p.m. will be assigned to the specific rating category for capitation purposes at the close of the following month.
- There are only 3 MDS-HC assessment codes in Section A.2 that SCO uses:
    1. Initial

    3. Routine assessment at fixed intervals (e.g., reassessments) and

    6. Change-in Status

- MDS-HC reassessments must be submitted annually.

- Change-in-Status MDS-HC submissions should occur whenever a member has a significant change in condition.
- Regarding Department of Developmental Services (DDS) Waiver Members: A person who is enrolled as a DDS Waiver Member cannot enroll in SCO unless the person first disenrolls from the DDS Waiver program.
- Section CC Referral Items states *"Complete at Intake Only";* **Please disregard this statement and complete this section for all MDS-HC assessments.**
    - In section CC.1 "Date case opened/reopened": Please enter the date of original enrollment to the SCO program.
    - The remaining questions in Section CC must be answered in relation to the current assessment.
  - Section G Informal Supports
    - Read and answer question G.1.e carefully:
      - Enter Code "1" if answer is NO
      - Enter Code "0" if answer is YES
    - Do not reverse these codes, e.g., do not use a zero "0" code to indicate "NO"
  - Section J Disease Diagnoses
    - RN must provide accurate diagnosis information in its entirety.
    - A drop-down box in section J.2 is provided for RN to choose diagnoses and the related ICD-10 codes.
    - If J.1.s "Any psychiatric diagnosis" has been coded, RN must enter a detailed diagnosis in section J.2 "Other current or more detailed diagnoses" and include the related ICD-10 code.
    - If J.1.y "Diabetes" has been coded, RN must enter a detailed diagnosis in section J.2 "Other current or more detailed diagnoses" and include the related ICD-10 code.
  - Section P Service Utilization
    - Section P.1 Formal Care must indicate the need and/or care provided to the member.
    - Section P.2 Special Treatments, Therapies, Programs must be completed as applicable.
    - There must be documentation in the member's plan record to support the member's skilled need(s).
  - Section Q Medications
    - Every MDS submission must include a complete medication list.
    - Section Q.5 must include Name, Dose, Form, Number taken and Frequency for each medication taken including PRNs and over the counter (OTC) medications.
  - Section R Assessment Information
    - Section R.1.a-R.1.c must be signed and dated by the RN upon completion of the MDS-HC.
    - The MDS-HC must be completed in its entirety and include all required information.

- The RN is the assessment coordinator who holds the legal responsibility to make sure the MDS-HC assessment is accurate and up to date with the member's current medical status prior to signing.
- All other signatures in section R: All dates must be before the RN signature date. It is not acceptable for other valid signatures to have dates after the signature date of the RN responsible for completing the assessment.

Members who Transfer between SCO Plans

If the member is transferring from one SCO Plan to another, the RN at the accepting SCO Plan must complete a new MDS-HC assessment.

- Section CC.1 Date case opened/re-opened – enter as transfer date
- Section A.2 Type of Assessment – enter as Initial
- Submit the transfer MDS-HC as an Initial Assessment