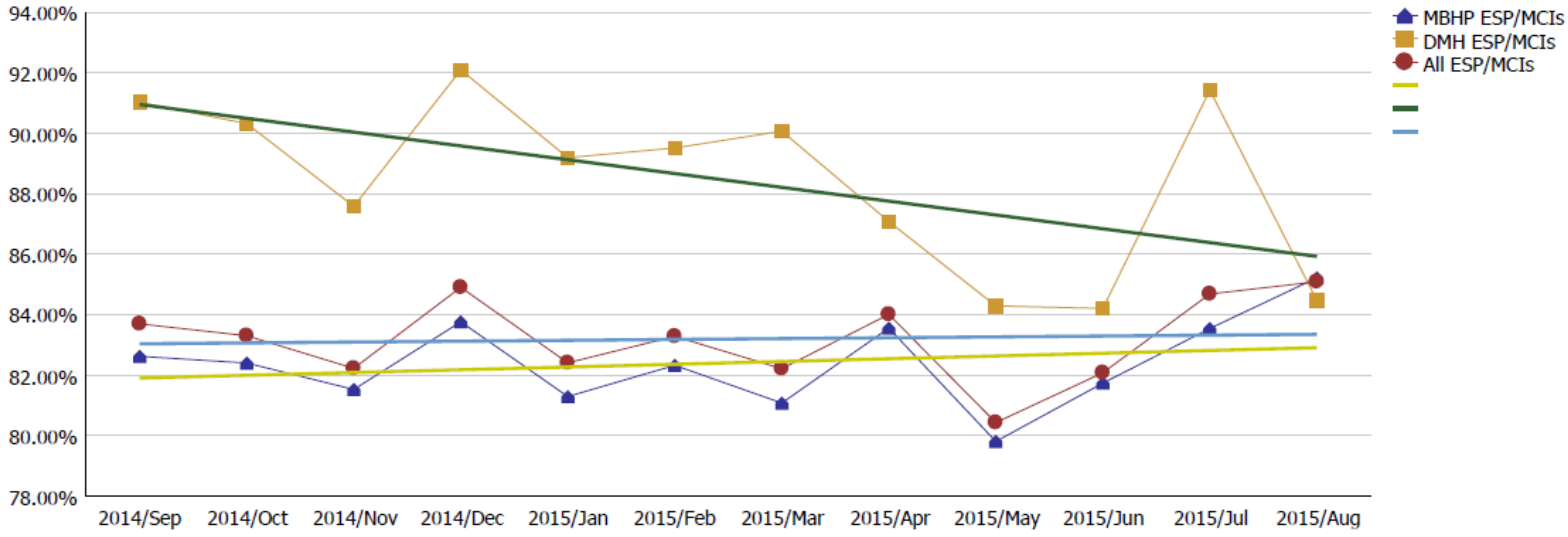
## Response Time
### Percent Within 60 minutes
MCI Youth 0-20, MBHB ESP/MCIs, DMH ESP/MCIs, All ESP/MCIs, Contracted Payers, Sep 2014 - Aug 2015




FY' 2016

| | 2015/Jul | 2015/Aug | FY2016 YTD AVG |
|---|---|---|---|
| MBHP ESP | 83.55% | 85.22% | 84.32% |
| DMH ESP | 91.43% | 84.47% | 87.88% |
| All ESPs | 84.69% | 85.09% | 84.88% |

Summary:

The average response time of MBHP ESPs within 60 min is trending up , MBHP response times range from 79.81% to 85.22%; FY' 2016 avg 84%

The average response time of DMH ESPs within 60 min is trending down, DMH response times range from 84.21% to 92.10%; FY' 2016 avg 88%

The average response time of All ESPs within 60 min is trending up , All ESPs response times range from 80.44% to 85.09% ; FY' 2016 avg 85%

# Appendix VII: MBHP Contract – Amendments 1-19 Incorporated

**COMMONWEALTH OF MASSACHUSETTS**
**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

## Contract for

## The MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
1 ASHBURTON PLACE
BOSTON, MA 02108

and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
1000 WASHINGTON STREET
BOSTON, MA 02118

September 30, 2012

This Contract, entered into effective this ____ day of _____, 2012, is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS," or "MassHealth") and the Massachusetts Behavioral Health Partnership (MBHP), a general partnership under ValueOptions, Inc., of Norfolk, VA, with principal offices at 1000 Washington Street, Boston, MA 02118 ("Contractor").

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

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

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

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

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

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

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

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# DEFINITIONS AND ACRONYMS

## Definitions

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

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

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

**Administrative Component of the BH Covered Services Capitation Rate** – a Per-Member (Covered Individual) Per-Day rate paid by EOHHS to the Contractor for the administration of the PCC Plan’s BHP.

**Adverse Action** – the following actions or inactions by the Contractor:

(1) the failure to provide MassHealth Covered Services in a timely manner in accordance with the waiting time standards in **Section 3.1.G.8**;

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

(3) the reduction, suspension, or termination of a previous authorization for a service;

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

- failure to follow prior authorization procedures;
- failure to follow referral rules;
- failure to file a timely Claim; and

(5) the failure to act within the timeframes in **Section 4.2.A.2.e** for making authorization decisions.

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

**Annual Payment Amount for the Care Management Program** – the amount equal to the sum of all the Engagement PPPM payments plus the sum of all CMP outcomes measurements incentive payments plus any amount that the Contractor includes for the CMP in the Administrative Component of the BH Covered Services Capitation Rate.

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

**Behavioral Health (BH)** – mental health and substance abuse.

**Behavioral Health Clinical Assessment** – the comprehensive clinical assessment of a Covered Individual that includes a full bio-psycho-social and diagnostic evaluation that informs Behavioral Health treatment planning. It is performed when a Covered Individual begins Behavioral Health treatment and is reviewed and updated during the course of treatment. Behavioral Health Clinical Assessments provided to Covered Individuals under the age of 21 require the use of the CANS Tool to document and communicate assessment findings.

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

**Behavioral Heath Covered Services Capitation Rate** – a Per-Member (Covered Individual) Per-Day (PMPD) and a Per-Member (Covered Individual) Per-Month rate paid by EOHHS to the Contractor for the provision of BH Covered Services to Covered Individuals. This actuarially sound capitation rate, as described in 42 CFR 438.6, is developed in accordance with generally accepted actuarial principles and practices, is appropriate for the populations to be covered and the services to be furnished under the Contract, has been certified as meeting the requirements of 42 CFR 438.6 by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board, and has been approved by the Centers for Medicare and Medicaid Services (CMS).

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

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

**BH Rate –** the portion of the CPCP Rate paid to Tier 2 or Tier 3 PCPR Providers by the Contractor for Behavioral Health Covered Services provided to PCC Panel Enrollees. The BH Rate is a Per-Member Per-Month amount specific to a Participating Site.

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

**BOH Appeal** – a written request to the BOH, made by a Covered Individual or Appeal Representative who has been authorized by a Covered Individual in writing to act on his/her behalf with respect to a BOH Appeal, to review the correctness of an Internal Appeal decision by the Contractor.

**Care Coordination –** management of care activities performed by the Contractor on behalf of a Covered Individual to improve health outcomes and may include medical, behavioral health, and pharmacy management and medication reconciliation among providers, agencies, and community social supports, as described in **Section 5.3**.

**Care Management Program (CMP)** – the administration and provision of certain clinical management and support activities to certain Enrollees and Providers, as described in **Section 6.2**.

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

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

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

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

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

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

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

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

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

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

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

**Comprehensive Primary Care Payment (CPCP) –** a risk-adjusted, per-PCC Panel Enrollee, per-month payment to a PCPR Provider for a defined set of Primary Care services and Behavioral Health Covered Services.

**CPCP Rate –** the rate paid to PCPR Providers for provision of the CPCP Covered Services.

**CPCP Covered Services –** the set of services specified in **Appendix J-5.**

**CPCP Tier –** one of three options for the CPCP, each of which includes a different set of services.

**Continuing Services** – disputed BH Covered Services provided by the Contractor to a Covered Individual notwithstanding the Date of Action, following an Adverse Action that terminates, modifies or denies BH Covered Services that the Covered Individual is receiving at the time of the Adverse Action, pending the resolution of an Internal Appeal and/or a BOH Appeal.

**Contract** – this agreement executed between the Contractor and EOHHS pursuant to EOHHS's Request for Responses (RFR) for the PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs, issued in 2011, and any amendments thereto. The Contract incorporates by reference all attachments and appendices thereto, including the Contractor's response to the RFR.

**Contractor** – the entity that executes this Contract with EOHHS.

**Contract Year** – except for Contract Year One, the 12-month period beginning on July 1 of each year.

**Contract Year One** – the period that begins on the Service Start Date and ends on June 30, 2013.

**Coverage Type --** a defined scope of medical services, other benefits, or both, that are available to individuals who meet specific MassHealth eligibility criteria. Coverage Types for this Contract include MassHealth Standard, Basic, CommonHealth, Family Assistance, Essential, and CarePlus. See 130 CMR 450.105 and 130 CMR 505.008 for an explanation of each Coverage Type.

**Covered Individuals** – MassHealth Members who are eligible to receive Behavioral Health Covered Services under the BHP, including PCC Plan Enrollees, MFP Waiver Participants, Children in the Care and/or Custody of the Commonwealth and children in MassHealth Standard or CommonHealth with other health insurance.

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

**Crisis Prevention Plan** – a plan directed by the Covered Individual, or in the case of Covered Individuals under age 18, their legal guardian, designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. The Crisis Prevention Plan provides a thorough checklist of the triggers that may lead to or escalate a psychiatric crisis. The plan also includes potential clinical presentations and a preferred disposition and treatment plan for each of these presentations as well as the Covered Individual's preferences with respect to involvement of the Covered Individual, his/her family and other supports, such as behavioral health providers, community social service agencies, and natural community supports. With the Covered Individual's consent, the plan may be implemented by an ESP, other BH Network Provider, the PCC, the staff from the CSA, or another provider. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Severe and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Severe Emotional Disturbance (SED) and their families.

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

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

**DMH Administrative Budget** – the total dollar amount paid to the Contractor for the DMH Specialty Programs Administrative Compensation Rate, covering the administrative costs for ESP for Uninsured Individuals and persons covered by Medicare only, Forensic Evaluations, and MCPAP.

**DMH Case Management** – a service operated by DMH which is performed in accordance with DMH regulations for DMH Clients. DMH Case Management includes those services enumerated in 104 CMR 29.00.

**DMH Clients** – for purposes of this Contract, individuals whom EOHHS identifies to the Contractor as being eligible for and recipients of DMH services.

**DMH Service Authorization –** the process by which a Member is found to be eligible and approved for a service provided through DMH.

**DMH Specialty Programs** – programs the Contractor manages under the Contract on behalf of DMH, including the Emergency Services Program (ESP) for Uninsured Individuals and persons covered by Medicare only, the Massachusetts Child Psychiatry Access Project (MCPAP), and Forensic Evaluations.

**DMH Specialty Programs Administrative Compensation Rate** – a dollar amount to be paid monthly by EOHHS to the Contractor for the administration of ESP Services for Uninsured Individuals including persons covered by Medicare only, the MCPAP program, and the Forensic Evaluation program.

**DMH Specialty Programs Total Compensation Rate Payment** – the amount paid by EOHHS to the Contractor pursuant to **Section 10.9** and **10.10**, which includes the DMH Specialty Programs Services Compensation Rate Payment plus the DMH Specialty Programs Administrative Compensation Rate.

**DMH Specialty Programs Service Compensation Rate** – the amount paid by EOHHS to the Contractor pursuant to **Section 10.10** for the provision of DMH Specialty Programs services.

**Designated Forensic Professional** – a physician or psychologist designated by the Department of Mental Health as qualified to perform a clinical assessment of the mental status of a prisoner and provide recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment. See M.G.L. c. 123, § 18(a).

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

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

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

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

**Earnings –** the Contractor's revenue or profit related DMH Specialty Programs Administrative Budget of this Contract. Earnings are an agreed-upon amount of the DMH Specialty Programs Administrative Budget, as described in **Section 10** and **Appendix H-1.**

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

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

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

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

**Emergency Service Programs (ESPs)** – the Network Providers, identified in **Appendix A-3**, that provide ESP Services as described in **Appendix A-1, Part III** in accordance with the requirements of the Contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Expected External Service Provision Adjustment (EESPA) –** a factor determined by EOHHS for use in calculating the CPCP, to reflect PCPR Panel Enrollees' receipt of CPCP Covered Services from health care providers other than the Contractor's Network Providers or certain Voluntary Pooled PCPR Providers.

**External Quality Review Activities (EQR Activities)** – activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.358.

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

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

**Forensic Evaluation Services** – a clinical assessment of the mental status of a prisoner, performed by a physician or psychologist designated by the Department of Mental Health as qualified to perform such examination in accordance with M.G.L. c. 123, § 18(a). Such examination shall including recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment, if so indicated.

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

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

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

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

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

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

**Hold Harmless Payment –** a payment made by the Contractor to PCPR Providers as compensation in the case where PCPR Provider incurs costs in excess of those compensated for by the CPCP, as calculated in Section 4.1 of the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract (**Appendix J-1**).

**Homeless** – individuals who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or who have no primary residence and utilize public areas for sleep, shelter, and daily living activities.

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

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

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

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

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

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

**Marketing** – as defined in 42 CFR 438.104, any communication, or in the case of "cold-call" Marketing, any unsolicited personal contact, from the Contractor, its employees, Providers, agents or Subcontractors to a Covered Individual who is not enrolled in the PCC Plan or its Behavioral Health Program that reasonably can be interpreted as intended to influence the Covered Individual to enroll in the PCC Plan or its BHP, or either to not enroll in, or to disenroll from, a MassHealth Managed Care Organization or the PCC Plan's BHP. This includes the production and dissemination by or on behalf of the Contractor of any Marketing Materials. Marketing shall not include any personal contact between a Provider and any Covered Individual who is a prospective, current or former patient of that Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Covered Individual.

**Marketing Materials** – as defined in 42 CFR 438.104, materials that are produced in any medium, by or on behalf of the Contractor, and that can reasonably be interpreted as intended for Marketing to Covered Individuals. This includes the production and dissemination by or on behalf of the Contractor of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, audio visual tapes, radio, television, billboards, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth Managed Care or Title XIX of the Social Security Act, and are targeted in any way toward Covered Individuals.

**Massachusetts Behavioral Health Access System** – a web-based searchable database maintained by the Contractor that contains up-to-date information on the number of available beds or available service capacity for certain MassHealth Behavioral Health services, including psychiatric hospitals, Community-Based Acute Treatment Providers, and providers of Intensive Home and Community-Based Services.

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

**MassHealth Basic** – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.005.

**MassHealth CommonHealth** – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.004.

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

**MassHealth Essential** – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.007.

**MassHealth Family Assistance** – the MassHealth Coverage Type that includes those individuals determined by EOHHS to meet the requirements of 130 CMR 505.006.

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

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

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

**MassHealth Standard** – the MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.002.

**Material Subcontractor** – any entity from which the Contractor procures, reprocures, or proposes to subcontract with, for the provision of all or part of its Administrative Services for any program area or function that relates to the delivery, management or payment of Covered Services, including but not limited to claims processing, the Care Management Program and other care management activities, PCC Plan Management Support Services, and Utilization Management.

**MCPAP for Moms –** a statewide program in the Commonwealth to assist medical professionals in supporting a mother's emotional and mental health during pregnancy and the year following birth or adoption. Service includes phone consultations with a MCPAP for Moms psychiatrist to discuss treatment options, personalized recommendations by a psychiatrist, community-based mental health resources and assistance in identifying and/or scheduling community-based mental health services that may include therapy, a psychiatrist, or a support group.

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

**Medicaid** – see MassHealth.

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

**Medical Home Load –** the portion of the CPCP Rate that provides compensation for transformation costs associated with non-billable services, as described in Section 4.1.A.2.a of **Appendix J-1**.

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

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

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

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

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

**Money Follows the Person (MFP) Demonstration** – A MassHealth demonstration program authorized through March 31, 2016, pursuant to a federal grant received by OHHS that seeks to assist eligible Members residing in long-term care facility settings to transition to community-based settings where they can receive home and community-based services. See definition of "Money Follows the Person Waivers," below.

**Money Follows the Person (MFP) Waivers** – Massachusetts waivers for persons participating in the MFP Demonstration and approved by CMS under Sections 1915(c) and 1915(b) of the Social Security Act. Massachusetts operates three separate MFP Waivers. The two 1915(c) Home and Community-Based Services (HCBS) waivers are the Money Follows the Person Residential Supports (MFP-RS) waiver and the Money Follows the Person Community Living (MFP-CL) waiver – each with different covered services and eligibility requirements. The third waiver is the 1915(b) Money Follows the Person Behavioral Health Managed Care (MFP-BH)

waiver. The MFP-BH waiver will serve all individuals enrolled in the MFP-RS and MFP-CL waivers who are not otherwise eligible for managed Behavioral Health benefits.

**MFP Waiver Participant** – a Covered Individual who is eligible for services pursuant to one of the MFP HCBS Waivers.

**MFP Waiver Case Manager** – an individual designated by EOHHS who is responsible for performing an assessment to determine the MFP Waiver Participant's care needs in the community. Based upon the MFP Waiver Case Manager's assessment, the MFP Waiver Case Manager will engage in a person-centered planning process with the MFP Waiver Participant, and develop an individual service plan. It is the MFP Waiver Case Manager's responsibility to monitor the provision of services pursuant to the MFP Waiver Participant's individual service plan, and also communicate the individual service plan to the appropriate agencies, organizations and providers; and coordinate the provision of services.

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

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

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

   For each of a. through c., above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.
2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as "Additional OPPCs."

**Outreach Target –** the projected number of Enrollees in each Tier the bidder will attempt to contact annually for Engagement in the Care Management Program each Contract Year.

**Participant –** a Covered Individual eligible for behavioral health services and who is enrolled in the Care Management Program.

**Participating Site –** a physical location from which a PCPR Provider provides the Primary Care Services required by the Primary Care Payment Reform Initiative. Participating Sites are listed in **Appendix J-3**.

**Patient-Centered Medical Home Initiative (PCMHI) Clinical Care Management Services** – services provided by a licensed nurse care manager employed by an EOHHS PCMHI participating practice. The services include stratification of the practice patient population, having contact with patients identified as high-risk no less frequently than every 30 days, case review and planning, including completing, analyzing, and updating as necessary medical bio-

psychosocial support and self-management support assessments, and providing intensive medical and medication management.

**Pay for Performance (P4P)** – Performance Incentive Arrangement payments the Contractor may earn as described in Contract **Sections 8** and **10**.

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

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

**Per-Member (Enrollee** or **Covered Individual) Per-Day (PMPD) –** the average daily amount to be paid per Enrollee or Covered Individual, depending on context.

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

**Performance Incentive Arrangement –** a payment mechanism under which the Contractor may earn payments for meeting targets in the Contract, to the extent that such payments are Actuarially Sound. See 42 CFR 438.6(c)4.

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

**Positive Parenting Program® (Triple P)** – an evidence-based family intervention program, developed by Triple P America, designed to prevent and treat behavioral and emotional problems in children and adolescents and create a family environment that encourages children and adolescents to realize their potential. Triple P draws on social learning and cognitive behavioral and developmental theory as well as research on risk factors associated with the development of social and behavioral problems in children to provide a multi-level parenting and family support training system. The goal of Triple P is to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support.

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

**Potential Enrollee –** a MassHealth Member who is subject to mandatory enrollment or who might voluntarily enroll in one of the Commonwealth's managed care entities but is not yet an enrollee of the managed care entity.

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

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

**Pre-Arraignment Protocol (PAP)** – a protocol that sets forth a legal-clinical assessment process which allows local police departments to obtain psychiatric hospitalizations, where appropriate, for persons who are arrested but not yet arraigned when the court is closed.

**Prevalent Languages** – those languages spoken by a significant percentage of Members in the Commonwealth, as determined by EOHHS. Currently, EOHHS has determined that Spanish is a Prevalent Language.

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

**Primary Care Activity Level (PCAL) –** a factor determined by EOHHS for use in calculating the CPCP, to reflect the age, sex, diagnoses or other characteristics of PCPR Providers' PCC Panel Enrollees.

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

**PCC Hotline** – the toll-free telephone line maintained by the Contractor to answer or refer PCC or other PCC Plan provider inquiries. Such inquiries may include, but are not limited to, questions about: the Contractor's responsibilities related to the PCC Plan, including reporting, quality management, operations, PCCs participating in PCMHI, the PCC Provider Contract (see **Appendix C-2**), and other topics as directed by EOHHS.

**PCC Member-Level Report –** a component of the PCC Plan Management Support Services. The reports shall contain clinical data about specific Enrollees to help PCCs and their service locations monitor and manage Enrollees' care in accordance with recommended guidelines.

**PCC Panel Enrollee –** an Enrollee who is assigned to the PCPR Provider. Panel Enrollees do not include MassHealth Members enrolled with an OneCare Plans or who have third-party insurance.

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

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

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

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

**PCC Plan Regional Network Managers** – Contractor staff dedicated solely to the Contract, with appropriate network management, QM, provider relations, and relevant clinical background and experience.
**PCC Provider Contract** – a PCC's written agreement with EOHHS to be a PCC in the PCC Plan.

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

**Primary Care Payment Reform Initiative (PCPRI** or **PCPR Initiative)** – an EOHHS care delivery program to begin in calendar year 2014 to improve access to care, member experience, quality of care, and overall efficiency in service delivery by emphasizing Patient-Centered Medical Homes, the integration of Primary Care services with Behavioral Health services and MassHealth's use of an alternative payment mechanism for participating providers.

**PCPR Provider –** a Primary Care Clinician that has signed the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract to participate in PCPR with MassHealth, a model of which is included as **Appendix J-1**. A list of PCPR Providers providing Tier 2 and Tier 3 PCPR Covered Services is included as **Appendix J-3**.

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

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

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

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

**Provider Agreement** – a binding agreement between the Contractor and a BH Network Provider that includes, among other things, all of the provisions set forth in **Section 3.1.C**.

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

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

**Rating Category (RC)** – a specific group of Covered Individuals for which a discrete BH Covered Services Capitation Rate applies, as described in **Section 10.2**.

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

**SBIRT (Screening, Brief Intervention and Referral to Treatment) –** an evidence based approach addressing adolescent substance use/abuse in health care settings.

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

**Serious Mental Illness** – a substantial disorder of thought, mood, perception, orientation or memory in an adult, which: significantly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; has lasted or is expected to last at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities; meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), as currently drafted and subsequently amended; and is not based on symptoms primarily caused by substance use, mental retardation or organic disorders.

**Serious and Persistent Mental Illness (SPMI)** – a mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders,

including delirium, dementia or amnesia; or (c) mental disorders due to a general medical condition not elsewhere classified; or (d) substance-related disorders.

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

**Service Compensation Rate** – a dollar amount to be paid monthly by EOHHS to the Contractor for the delivery of ESP Services to Uninsured Individuals and persons covered by Medicare only, Forensic Evaluation services and MCPAP services as set forth in this Contract.

**Service End Date** – the date, as determined by EOHHS, on which the Contractor's responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract shall terminate.

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

**Southeast Area** – is comprised of Bristol, Plymouth, Barnstable, Dukes, Nantucket and a portion of Norfolk counties and includes the following municipalities:

| | | | | |
|---|---|---|---|---|
| Abington | Dennis | Harwich | Onset | Swansea |
| Acushnet | Dighton | Holbrook | Orleans | Taunton |
| Aquinnah | Duxbury | Hyannis | Osterville | Tisbury |
| Attleboro | East Bridgewater | Kingston | Pembroke | Truro |
| Avon | Easton | Lakeville | Plymouth | Vineyard Haven |
| Barnstable | Eastham | Mansfield | Plympton | Wareham |
| Berkley | Edgartown | Marion | Pocasset | Wellfleet |
| Bourne | Fairhaven | Marshfield | Provincetown | West Bridgewater |
| Brewster | Fall River | Mashpee | Raynham | Westport |
| Bridgewater | Falmouth | Mattapoisett | Rehoboth | West Tisbury |
| Brockton | Freetown | Middleborough | Rochester | Whitman |
| Carver | Gay Head | Nantucket | Rockland | Woods Hole |
| Chatham | Gosnold | New Bedford | Sandwich | Yarmouth |
| Chilmark | Halifax | North Attleboro | Seekonk | |
| Cotuit | Hanover | Norton | Somerset | |
| Dartmouth | Hanson | Oak Bluffs | Stoughton | |

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

**Tier** – a division or category within the Care Management Program's system of stratification.

**Tier 1 Billable Services Rate** – the portion of the CPCP for payment of Tier 1 medical services.

**Tier 1 CPCP Covered Services –** medical expenses included within the CPCP Covered Services as detailed in **Appendix J-5**.

**Tier 2 CPCP Covered Services –** a minimum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

**Tier 3 CPCP Covered Services –** a maximum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

**Uninsured Individuals** – those individuals who are not MassHealth or CommCare eligible for any reason, and do not have commercial insurance.

**Urgent Care Services** – services that are not Emergency Services or routine services.

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

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

**Voluntary Pooled PCPR Providers –** PCPR Providers that aggregate the number of PCC Panel Enrollees in each PCPR Provider's panel by choice, in accordance with the PCPR Provider's PCC Plan Contract with EOHHS.

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

### Acronyms

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

ABA – Applied Behavioral Analysis
ACA (or PPACA) – the Patient Protection and Affordable Care Act of 2010
ALP **–** Alternative Lock-up Programs
AND – administratively necessary day
BBA – Balanced Budget Act of 1997
BH – behavioral health
BHP – behavioral health program
BOH – Board of Hearings
BORIM – Board of Registration in Medicine
CANS – child and adolescent needs and strengths
CBHI – children's behavioral health initiative
CFR – Code of Federal Regulations
CMP – care management program
CMR –Code of Massachusetts Regulations
CMS – the federal Centers for Medicare and Medicaid Services
CPCP **–** Comprehensive Primary Care Payment
CSA – community service agency

CSMP – controlled substance management program
DCF – the Massachusetts Department of Children and Families
DDS – the Massachusetts Department of Developmental Services
DHCFP – the Massachusetts Division of Health Care Finance and Policy
DMH – the Massachusetts Department of Mental Health
DPH – the Massachusetts Department of Public Health
DPH/BSAS – Bureau of Substance Abuse Services of the Mass. Department of Public Health
DRM – Document Review Measure
DSRA – direct service reserve account
DUR – drug utilization review
DYS – the Massachusetts Department of Youth Services
ECC – Enhanced Care Coordination
ED – emergency department
EESPA **–** Expected External Service Provision Adjustment
EOHHS – the Massachusetts Executive Office of Health and Human Services
EPSDT – Early and Periodic Screening, Diagnosis and Treatment
ESP – emergency services program
EQR –external quality review
EVS – Eligibility Verification System
FFP – federal financial participation
FFS – fee-for-service
FTE – full-time equivalent
FY – fiscal year
HCBS – Home and Community-Based Services
HEDIS – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act of 1996
HNA – Health Needs Assessment
IBNR – incurred but not reported
ICC – intensive care coordination
ICM – intensive clinical management
ICMP – Integrated Care Management Program
LEIE – Office of the Inspector General List of Excluded Individuals Entities
MBR – MassHealth benefit request (application) form
MCO – managed care organization
MCPAP – Massachusetts child psychiatry access project
MFD – Medicaid Fraud Division
MFP – Money Follows the Person
MGL – Massachusetts General Laws
MID – member identification number
MIS – management information system
MLR – PCC Member-Level Report
MMIS – Medicaid Management Information System
MSS – PCC Plan management support services
NCQA – National Committee for Quality Assurance
NPI – national provider identifier
OCA – Office of Clinical Affairs
P4P – pay for performance
PAP – pre-arraignment protocol

PBCM – Practice Based Care Management
PBHMI – Pediatric Behavioral Health Medication Initiative
PCAL – Primary Care Activity Level
PCC – primary care clinician
PCMHI – patient-centered medical home initiative
PCP – primary care practitioner
PCPR – primary care payment reform
PD – PCC Performance Dashboard
PID/SL – provider identification and service location
PIHP – Prepaid Inpatient Health Plan
PMPD – per member (covered individual or enrollee) per day
PMPM – per member (covered individual or enrollee) per month
POPS – Pharmacy Online Processing System
PPHSD – Preventive Pediatric Health-Care Screening and Diagnosis
PPPM – per participant (in the Care Management Program) per month
PPSS – Provider Partner Support Services
S2BI – Screening to Brief Intervention
SBIRT – Screening, Brief Intervention, and Referral to Treatment
SED – serious emotional disturbance
SRE – serious reportable event
TPL – third-party liability
QI – quality improvement
QM – quality management
UM – utilization management
VG – Virtual Gateway

# GENERAL ADMINISTRATIVE REQUIREMENTS

## Transition to the Contractor

### Transfer of Responsibilities

The Contractor shall:

Ensure that there is no interruption of Behavioral Health Covered Services to Covered Individuals and Uninsured Individuals.

Ensure that the existing toll-free telephone number (800-495-0086), is operative at the Contractor's office as of midnight (Eastern Time) on the Service Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The number shall continue to offer all appropriate menu options to provide Contract-related information to PCCs, Network Providers, and Covered Individuals, including the PCC Plan Hotline. (See **Section 9.7** for specific telephone system requirements.)

At least 30 days prior to the Service Start Date, obtain all records, reports and data related to the previous PCC Plan's Behavioral Health Program contract ("previous BHP contract") in the manner and method specified by EOHHS, including but not limited to information pertaining to:

Utilization:

Preauthorization and continuing stay (concurrent review) files for all Levels of Care; and

Management reports identifying the next scheduled concurrent review and discharge review dates;

Care Management, including all current authorizations, individual care plans, clinical case notes and utilization history for individuals receiving Care Coordination, Targeted Outreach, and Intensive Clinical Management, including as of 14 calendar days before the end of the previous BHP contract;

Prior authorizations for all Levels of Care:

Inpatient Services admissions for the last 30 calendar days of the previous BHP contract;

Outpatient Services authorizations ending on or before 30 calendar days after the last calendar day of the previous BHP contract;

Diversionary Services for the last 30 calendar days of the previous BHP contract;

Clinical notes and individual case information;

Provider credentialing;

Provider fraud investigations;

Complaints from Covered Individuals;

Grievances from providers and Covered Individuals;

Adverse Incident investigations;

Quality Management plan;

Quality Improvement Project records;

Information on the previous BHP provider network, including:

A provider list containing the provider's name, type of provider, address, administrative contact person and clinical contact person;

The previous BHP contract's network management plan with provider files and improvement goals; and

All Appeals and Claim reviews filed under the previous BHP contract and not yet investigated and resolved.

**Implementation**

The Contractor shall:

Develop and submit to EOHHS for approval, no later than 14 days after notification that EOHHS has selected it for Contract negotiations, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first Contract Year, including the readiness activities for the Service Start Date.

Provide EOHHS with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the Contractor's current stage of readiness to perform all Contract obligations. Until the Service Start Date, the Contractor shall provide an update every two weeks to the work plan and timeline, and thereafter as often as EOHHS determines is necessary.

Unless otherwise agreed to by EOHHS, submit to EOHHS all deliverables, including but not limited to those identified in **Appendix B**, that must be in place by the times specified in this Contract; or, if not specified, in sufficient time to permit any EOHHS-identified modifications to be made by the Service Start Date.

Ensure that all workplace requirements EOHHS deems necessary, including but not limited to office space, post office boxes, telephones and equipment, are in place and operative as of the Service Start Date.

Establish its Provider Network and maintain existing Provider Agreements with such Providers, all in accordance with the provisions set forth in **Section 3.1.C**.

Perform all functions described in the Contract as of the Service Start Date, unless otherwise specified or agreed to by EOHHS.

**Clinical Transition Plan**

The Contractor shall:

Prepare to assume responsibility as of the Service Start Date for the clinical management, service authorization, and Claims payment functions for Covered Individuals who are receiving Inpatient Services or have open Outpatient or Diversionary Service authorizations or registrations on the Service Start Date.

No later than one month prior to the Service Start Date, prepare to accept transfer of all authorizations that are valid for dates of service after the Service Start Date; and each business day beginning 30 days prior to the Service Start Date, transfer from the previous BHP contract information on all services that were registered the previous day and that are valid for dates of service after the Service Start Date.

Prior to the Service Start Date, ensure that sufficient staff have been recruited, hired and trained to perform all requirements of the Contract on the Service Start Date, unless otherwise agreed to by the parties.

Prior to the Service Start Date, provide written instructions to those network and non-network providers from the previous BHP contract regarding any changes from the previous BHP contract to the Contractor's service authorization requirements and procedures for using the service authorization system, and schedule training sessions with Network Providers to review policies and procedures for any such changes, as necessary.

For Covered Individuals who have registered or prior-authorized BH Covered Services in place by the day before the Service Start Date, honor all such authorizations through their end dates.

For any Covered Services authorized under the previous BHP contract, adjudicate and pay claims from BH Network Providers under the previous BHP contract for services provided on or after the Service Start Date.

**Contract Requirements for EOHHS Readiness Review**

Prior to the Service Start Date, and no later than 60 days prior to enrollment of Covered Individuals into the Contractor's Plan, and at other times during

the Contract period at the discretion of EOHHS, EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible. The EOHHS Readiness Review may include on-site review. The Contractor shall demonstrate to EOHHS satisfaction that all elements required for readiness are in place, including but not limited to:

All deliverables that EOHHS has specified must be in place prior to the Service Start Date, as set forth in **Appendix B**;

Network Provider composition and access;

Staffing, including Key Personnel and functions directly impacting on Enrollees;

Capabilities of Material Subcontractors;

Care Management capabilities;

Content of Provider Agreements, including any Provider performance incentives;

Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities);

Comprehensiveness of quality management/quality improvement and Utilization Management strategies;

Internal Grievance and Appeal policies;

Fraud and Abuse detection and protocols, Third-Party Liability Benefit Coordination and Recovery and program integrity;

Financial solvency;

Information systems, including claims payment system performance, interfacing and reporting capabilities, validity testing of Encounter Data, IT testing and security assurances.

Covered Individuals may not be enrolled with the Contractor until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

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 Service Start Date, and EOHHS does not agree to postpone the Contract Service Start Date or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

## Contractor's Organization

### Organizational Philosophy

The Contractor shall maintain and make available to EOHHS upon request an organizational statement that describes the Contractor's philosophy, operating history, mission, organizational structure, ownership structure, and plans for future growth and development of its organization.

### Location

The Contractor shall:

Unless the parties agree otherwise, maintain for the term of the Contract a principal place(s) of business in Massachusetts that is acceptable to EOHHS.

Maintain for the term of the Contract a backup site, separate from its principal place of business, that fulfills the Contract requirements for disaster recovery described in **Section 13.36**.

Notify EOHHS and obtain EOHHS's approval of any proposed change to the location of the Contractor's principal place(s) of business, at least 30 calendar days before making the proposed change.

Upon EOHHS's request for good cause, and upon adequate notice, work with EOHHS to identify an alternative location for the Contractor's principal place(s) of business, and, as agreed to by the parties, move its operation to said location.

### Contract Officer

The Contractor shall:

Designate a qualified individual dedicated solely to the Contract to serve as Contract Officer who shall act as the liaison between the Contractor and EOHHS, authorized and empowered to represent the Contractor in all matters pertaining to the Contract. Such designation may be changed during the period of the Contract only by written notice to and approval by EOHHS.

Ensure that the Contract Officer holds an executive-level key personnel position in the Contractor's organization, except that the Contractor may propose for EOHHS's prior review and approval an alternate structure for the Contract Officer position.

The Contract Officer's responsibilities shall include:

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

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

Overseeing all Contract-related activities by the Contractor, each Material Subcontractor and all other subcontractors, including coordinating with the Contractor's key personnel as described in **Section 2.2.F.1**;

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

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

Coordinating requests and activities among the Contractor, all subcontractors, and MassHealth/DMH staff;

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

Tracking the compliance of all Contract requirements and deliverables and maintaining records of all compliance activities and compliance dates using an electronic software tool or other similar mechanism such as a spreadsheet. Tracking of Contract compliance shall be in a format that can be shared with EOHHS upon request or an agreed-upon reporting schedule. Such tool or tracking mechanism shall be maintained in the Contract as **Appendix B-2**. All deliverables, reports, contracts, subcontracts, agreements and any other documents subject to EOHHS approval shall be provided to EOHHS in accordance with Contract requirements.

**Communications**

Access to Administrative Personnel

The Contractor shall:

Maintain a local telephone line for administrative personnel, for communicating with EOHHS in an effective and timely manner and ensuring that EOHHS is informed of all circumstances that materially affect service delivery or the management and administration of the Contract;

Ensure that its system for communicating with EOHHS includes direct telephone access, voice mail and electronic mail capacity for, at a minimum, all of the Contract's key personnel and senior-level management staff;

Require all staff to utilize a voice mail messaging system to inform callers of all planned and unplanned absences from work, to check their messages periodically when working offsite, and to identify a designee who will handle their calls in their absence;

Provide to EOHHS, when available and whenever changes occur, a list of telephone numbers, titles and e-mail addresses of, at a minimum, the Contractor's key personnel and senior-level management staff; and

Ensure that the Contractor utilizes the EOHHS secure e-mail system for all communications involving Protected Health Information (PHI).

Quality Oversight of Written Materials

The Contractor shall submit all materials intended for general distribution to Covered Individuals, Uninsured Individuals, Providers and Primary Care Clinicians (PCCs) up to the standards of professional business standards, and in compliance with 42 CFR 438.10, before submitting them to EOHHS for review and approval and prior to publication.

**Organizational Structure and Staffing**

The Contractor shall:

Submit to EOHHS for approval, at least 60 calendar days prior to the Service Start Date an organizational chart depicting the functions and reporting relationships for the performance of the Contract;

Notify EOHHS in writing at least 30 calendar days prior to making any significant changes to its internal organizational structure;

Recruit and maintain an appropriately qualified and diverse workforce, sufficient in number for the efficient execution of all Contract responsibilities;

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

Make best efforts to maintain a staff that reflects the cultural, linguistic and demographic characteristics of Covered Individuals, including a sufficient number of bilingual staff capable of communicating in English and Spanish, and other languages as appropriate; and

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

**Key Personnel and Senior Management Staff**

The Contractor shall identify key personnel and senior-level management staff with clearly delineated authority over all functions of the Contract.

Key Personnel

The Contractor shall:

Employ the following or similarly titled or functional full-time personnel designated as key personnel under the Contract, employed in the key personnel position only upon review by EOHHS:

Chief Executive Officer;

Chief Financial Officer;

Chief Operating Officer;

Chief Information Officer;

Chief Medical Officer (see **Section 4.1.B.4**);

Associate Medical Directors (see **Section 4.1.B.4**);

Behavioral Health Plan Network Management Director;

PCC Plan Management Support Services Director (see **Section 5.2.A.1**)

Contract Officer (see **Section 2.2.C**).

EOHHS further reserves the right to be informed of a decision by the Contractor to dismiss any of the key personnel.

Develop and maintain detailed job descriptions for each key personnel position that will have ongoing responsibility for Contract functions.

Designate the Chief Executive Officer as the person responsible for the Contract in its entirety and who ensures that there is coordination and integration, as appropriate, of functions across the activities related to BH services, administrative services related to the PCC Plan, the full range of Care Management activities, and Specialty Services managed by the Contractor.

Submit the name, title and curriculum vitae of each person holding a key personnel position to EOHHS prior to the Service Start Date and whenever a change occurs.

Non-Performance

The Contractor shall:

Respond promptly to any EOHHS concerns regarding the performance of any key personnel under the Contract.

Take any action related to any personnel that the Contractor reasonably determines is necessary to ensure full compliance with the terms of the Contract, and notify EOHHS of such actions.

Contract Representative(s) and Liaison(s)

Prior to the Service Start Date and whenever a change occurs, the Contractor shall submit to EOHHS the name(s) and titles(s) of a senior-level or executive individual(s) who will have responsibility for ongoing administrative, clinical, fiscal and programmatic interaction with EOHHS, DMH central and area offices, and DCF central and regional offices.

**Staff Training**

The Contractor shall:

Develop, and submit to EOHHS for review and approval prior to the Service Start Date, a training program and curriculum that provides its staff with the knowledge and skills they require to effectively, correctly and competently perform their functions under the Contract.

Thereafter maintain the training program and update it at EOHHS's request. In addition, EOHHS reserves the right to require additional training programs at its discretion.

Evaluate the effectiveness of the training program on an annual basis or as directed by EOHHS

**Material Subcontractors**

The Contractor shall:

By the Service Start Date and subsequently at least 60 days prior to the date the Contractor expects to execute a contract for a Material Contractor, submit to EOHHS for review and approval the identity of any Material Subcontractors the Contractor has hired to perform any of the requirements of the Contract and the names of their principals, along with the Material Subcontractor Checklist and completed federally required disclosure forms (see **Appendix B-4**), if required in accordance with **Section 13.2.** The Contractor shall request such approval in writing and submit with that request a completed Material Subcontractor Checklist using the template provided by EOHHS and attached hereto as **Appendix B-3**, as may be modified by EOHHS from time to time. The Contractor must describe the process for selecting the Material Subcontractor, including the selection criteria used. The Contractor shall provide EOHHS

with any additional information requested by EOHHS in addition to the information required in the Material Subcontract Checklist;

Maintain all agreements and subcontracts relating to this Contract in writing. All such agreements and subcontracts shall fulfill applicable requirements of 42 CFR Part 438, and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to privacy and confidentiality (**Section 14**) and record retention (**Section 13.21**);

Remain fully responsible for meeting all of the requirements of the Contract regardless of whether the Contractor subcontracts for the performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibility under the Contract;

Actively monitor the quality of care provided to Covered Individuals under any Provider Agreements and any other subcontracts;

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

Have a written agreement with the Material Subcontractor that specifies the activities and report responsibilities delegated to the Material Subcontractor and provides for revoking delegation or imposing other sanctions if the Material Subcontractor's performance is inadequate;

Monitor the Material Subcontractor's performance on an ongoing basis and subject it to formal review annually. If any deficiencies or areas for improvement are identified, the Contractor and the Material Subcontractor shall take corrective action;

Notify EOHHS in writing immediately upon notifying any Material Subcontractor of the Contractor's intention to terminate any such subcontract;

Submit annually to EOHHS a list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are certified Minority Business Enterprises. The Contractor shall submit an updated list at least 30 days in advance of any changes to the list or as otherwise directed by EOHHS.

**Organizational Certifications, Requirements and Prohibitions**

EOHHS shall have the sole discretion and authority to determine whether the Contractor has satisfied the requirements of subsections **1** and **2** below.

Certification of Readiness to Perform

The Contractor hereby represents and warrants that as of the Service Start Date it has performed all of the requirements set forth in **Section 2.1** of this Contract; and has submitted to EOHHS for review and approval all deliverables as agreed to by the parties, including but not limited to those identified in **Appendix B-1**, that are required to be submitted by the Service Start Date; and that on the Service Start Date and at all times

during the term of the Contract it is ready, willing and able to perform all of the requirements of the Contract without modification.

Business Requirements and Representations and Warranties

The following definitions apply to this **Section 2.2.I**:

**Related Entity** – any and all of the Contractor's partners, Parents, subsidiaries, and any other entity directly or indirectly related to the Contractor, as well as any and all of the Contractor's Material Subcontractors, and such Material Subcontractors' partners, Parents, subsidiaries, and any other entity directly or indirectly related to any such Material Subcontractor.

**Restricted Activity** – an activity that involves directly or indirectly owning or controlling any interest in, or operating, managing, or otherwise engaging in any business activity with any entity in Massachusetts, New Hampshire, Rhode Island, Vermont, Maine, Connecticut or New York that delivers or manages the delivery of BH Covered Services listed in **Appendix A-1** of this Contract to Covered Individuals or Uninsured Individuals.

The Contractor shall comply with each of the following requirements and hereby represents and warrants that it does so comply and will continue to so comply at all times during the term of this Contract:

The Contractor and each Material Subcontractor, if any, is organized primarily for the purpose of administering and coordinating the delivery of health care services.

Neither the Contractor nor any Related Entity engages in a Restricted Activity.

Notwithstanding the provisions of subsection **2)**, the Contractor or a Related Entity may engage in a Restricted Activity, as specified by EOHHS, if the Contractor has requested and received EOHHS's prior written approval to do so, in accordance with subsection **3**, below.

Request for Contractor or Related Entity to Engage in Restricted Activity and Plan to Assure against Conflict

The Contractor shall request in writing EOHHS's approval of any proposal under which the Contractor or any Related Entity would engage in a Restricted Activity. EOHHS may in its sole discretion approve, modify or deny, in whole or in part, the Contractor's request or any proposed plan. Such request shall:

Specifically describe the Restricted Activity in which the Contractor or Related Entity proposes to engage;

Specifically describe the reasons for the request;

Include a statement certifying that the Contractor's proposed plan ensures that the Contractor is in compliance with all applicable state and federal laws and regulations; and

Contain a complete description of the Contractor's specific plan to ensure that the Contractor will not favor any Network Provider with which the Contractor or a Related Entity proposes to engage in a Restricted Activity. To favor such a provider includes without limitation:

preferentially, disproportionately or inappropriately utilizing that Network Provider's services;

offering that Network Provider preferential rates or any other preferential form of remuneration;

applying lower performance, quality of care, or any other standards to that Network Provider; or

otherwise treating that Network Provider in any preferential or disparately advantageous way.

General Prohibition against Conflicts with Contractual Obligations

The Contractor and its Material Subcontractor(s) shall have no interest, including without limitation financial, legal or other business interest, nor shall the Contractor or its Material Subcontractor(s) engage in any activity at any time during the term of this Contract that, in EOHHS's sole determination, conflicts with any of the Contractor's obligations hereunder, specifically including the performance of services required under this Contract. Without limiting the generality of the foregoing, EOHHS requires that:

Neither the Contractor nor any Material Subcontractor have any financial, legal contractual or other business interest in EOHHS's Customer Services vendor or such vendor's subcontractors, if any; and

Neither the Contractor nor any Material Subcontractor nor any Related Entity engage in any Restricted Activity, except in accordance with this **Section 2.2.I**.

Required Termination of Agreements with Certain Providers and Other Entities

If EOHHS in its sole discretion determines that the Contractor has failed to comply with or otherwise satisfy the requirements of subsections **3** and **4**, above, EOHHS may require the Contractor to terminate:

Any such Network Providers from its Network; or

Any agreements or other arrangements with non-Network Providers or other entities in which or with which the Contractor has an interest or engages in an activity that is inconsistent with the terms of this Contract.

EOHHS Approval of Contractor's Corporate Policies

The Contractor shall, upon EOHHS's request, provide for review and approval any internal policies, procedures or practices developed by the Contractor, its Parent(s) or affiliates that may affect the Contractor's performance of its obligations under the Contract, including without limitation:

Policies that could affect the Contractor's ability to provide adequate staff to perform its Contract obligations;

Choice of vendors for administrative services;

The imposition of limits on administrative spending; and

Those related to the Contractor's purchase of supplies, materials, and telephone and information systems necessary to perform its obligations under the Contract.

Requirements Related to the Contractor's Financial Condition and Structure

The Contractor hereby represents and warrants that the Contractor and each of its Material Subcontractors is in sound financial condition and will remain so at all times during the term of this Contract.

As a condition of the Contract, the Contractor shall comply and shall ensure that each Material Subcontractor complies with each of the following requirements, and hereby represents and warrants that it and each Material Subcontractor does so comply and will continue to so comply at all times during the term of this Contract.

If the Contractor or any Material Subcontractor is organized as a partnership or joint venture:

All entities that constitute the partners that the Contractor comprises as of the date of the execution of the Contract shall sign the Contract and shall be jointly and severally liable for all obligations under and relating to the Contract for the duration of the Contract and all additional periods required thereunder, notwithstanding any inconsistent act or agreement by or among any of the partners;

Upon request, the Contractor and each Material Subcontractor shall immediately submit to EOHHS its partnership agreements, any amendments

thereto, and any other documents related to its partnership obligations as they relate to the Contract;

During the term of the Contract, the Contractor and each Material Subcontractor shall submit to EOHHS all proposed changes to their respective partnership agreements for EOHHS's prior review and approval prior to execution, including but not limited to changes related to adding to or otherwise changing the partners that the Contractor and each Material Subcontractor comprised as of the date of Contract execution;

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent, if any, of each and every business partner in order to guarantee and secure any obligations set forth in this Contract.

If the Contractor or any Material Subcontractor is a publicly traded corporation:

All filings submitted to the Securities and Exchange Commission by the Contractor or Material Subcontractors shall contemporaneously be submitted to EOHHS.

All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s) of the Contractor, if any, in order to guarantee and secure any obligations set forth in this Contract.

If the Contractor or any Material Subcontractor is a closely held corporation:

All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s), if any, of the Contractor in order to guarantee and secure any obligations set forth in this Contract.

At the request of EOHHS, the Contractor shall provide and shall require each Material Subcontractor to provide EOHHS with documentation relating to organizational and financial structure, including but not limited to:

the name(s) and address(es) of any Parent organization(s), all partially or wholly owned subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor; and

the names and occupations of the members of the Contractor's Board of Directors, and of the subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor.

The Contractor hereby represents and warrants that its provision against the risk of insolvency is adequate to ensure that Covered Individuals will not be liable for the Contractor's debts if the Contractor becomes insolvent.

Requirements Related to the Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations, including but not limited to those contained in **Section 14**, no later than the compliance date of each of those requirements or regulations;

It shall at all times subsequent to the applicable compliance dates be in compliance with such requirements and regulations; and

It shall work cooperatively with EOHHS on all activities related to compliance with HIPAA requirements, as directed by EOHHS.

Certification of Capacity to Meet Access Standards

The Contractor hereby represents and warrants that at all times during the term of the Contract it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in **Sections 3.1.G.6** and **3.1.G.7**.

Certification of NCQA Accreditation Status

The Contractor will submit current NCQA status including the schedule for accreditation and/or the schedule for remedies necessary for accreditation.

**Compliance with Data Certification, Program Integrity and Prohibited Affiliation Requirements**

As a condition of receiving payment under this Contract, the Contractor must comply with all applicable data certification, program integrity and prohibited affiliation requirements at 42 CFR 438.600 et seq., and as described in **Sections 3.7.H, 11.1** and **11.2**.

**Delivery of Services and Coordination of Services**

**Delivery of Services to Covered Individuals**

The Contractor shall:

Be responsible for ensuring the delivery of all BH Covered Services as they are described in **Appendix A-1** to all Covered Individuals that are eligible on the date of service.

Arrange, coordinate, authorize and pay for the provision of all Medically Necessary BH Covered Services.

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

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

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

prevent, diagnose, or treat the Covered Individual's health impairments;

assist the Covered Individual to achieve age-appropriate growth and development; and

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

Not arbitrarily deny or reduce the amount, duration, or scope of a required BH Covered Service solely because of diagnosis, type of illness, or condition of the Covered Individual. The Contractor may place appropriate limits on a BH Covered Services on the basis of Medical Necessity and utilization management, however such limitation are still to be considered an Adverse Action.

Orient the provision of BH Covered Services to the Covered Individual's strengths and preferences, his/her aspirations for recovery, and

encouragement of overall health and wellness. For Covered Individuals under age 18, actively involve parent(s) or legal guardian(s) in treatment.

Allow each Enrollee to choose his or her health professional to the extent possible and appropriate.

**Delivery of Services to the Uninsured**

The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary ESP Services without regard to enrollment in the BHP.

**Third-Party Liability Benefit Coordination and Recovery**

The Contractor shall:

By the Service Start Date, develop and submit to EOHHS for approval a work plan for Third-Party Liability (TPL) benefit coordination and recovery that:

Ensures that MassHealth is the payer of last resort for the BH Covered Services provided under this Contract;

Ensures recovery of funds inappropriately paid to Network Providers;

Avoids payment for all Claims or services that are subject to third-party payment;

Ensures that the Contractor identifies and determines the legal liability of third parties to pay for services furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only;

Includes tasks and time frames associated with the plan; and

Addresses systems and resources required to perform at a minimum the following activities:

Identification of Covered Individuals and Uninsured Individuals who have other health insurance, and notification of EOHHS with respect to Covered Individuals; and

Reporting to EOHHS information on cost avoidance and recovery amounts.

Retain any payments recouped from Network Providers as a result of the discovery of TPL, deposit them into the Direct Service Reserve Account (DSRA) (see **Section 10.12.A**) and use all such recoveries to offset BHP expenditures related to the delivery of BH Covered Services.

Unless otherwise directed by EOHHS, coordinate the Behavioral Health benefits of Covered Individuals with TPL with the other insurance resource, such as Medicare or commercial insurance, as described in **Section 2.3.D.1**. In

order to meet this requirement, the Contractor shall have all necessary changes to its operations in place by the Service Start Date, and shall continue to make all appropriate changes to its operations in compliance with any new policies from the EOHHS TPL Unit, including but not limited to changes to the following:

Management information systems;

Claims authorization systems;

Claims payment systems;

Staffing within the Claims Operation Department; and

Reporting.

**Claims Payment Requirements for Covered Individuals under Age 21 with TPL**

The Contractor shall ensure that:

Providers who provide BH Covered Services to Covered Individuals with TPL make diligent efforts to identify and obtain payment from all other liable parties, including insurers, as described in 130 CMR 450.316;

If a third-party resource is identified after the Provider has already billed and received payment from the Contractor, the Provider promptly returns any payment it received from the Contractor and ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

Providers who submit Claims for Covered Individuals who have Medicare in addition to Medicaid:

bill the Medicare fiscal intermediary or carrier in accordance with their billing rules, including using the appropriate Medicare claim form and format;

accept assignment according to Medicare instructions; and

follow the Contractor's billing instructions, including any billing instructions specific to Medicare crossover claims.

It does <u>not</u> pay Providers:

who do not make diligent efforts to obtain payment from other liable parties; or

for services provided to a Covered Individual, if on the date of service the Covered Individual had other health insurance, including Medicare, that may have covered the service, and

the Provider did not participate in or resort to the Covered Individual's other insurance plan, including Medicare.

The Contractor shall establish the following payment limitations:

Payment shall not exceed the Covered Individual's liability, including co-insurance, deductibles and copayments; or the Provider's charges or the Contractor's payment amount, whichever is less; and

For Covered Individuals under 21 with Medicare, the payment amount shall not exceed the coinsurance and deductible amounts as reported on the explanation of benefits or remittance advice from Medicare; the Contractor's payment amount, or the Medicare-approved amount.

The terms of this Section 2.3.D. apply to Applied Behavioral Analysis services provided to Covered Individuals.

**Covered Individuals – No Liability for Payment**

The Contractor shall ensure, in accordance with 42 USC § 1396u-2(b)(6) and 42 CFR 438.106, that a Covered Individual is not held liable for:

Debts of the Contractor, in the event of the Contractor's insolvency;

BH Covered Services provided to the Covered Individual in the event that:

the Contractor fails to receive payment from EOHHS for such services; or

a Provider fails to receive payment from EOHHS or the Contractor for such services; or

Payments to a Network Provider in excess of the amount that would be owed by the Covered Individual if the Contractor had directly provided the services.

Any cost-sharing imposed on Covered Individuals shall be in accordance with 42 CFR 447.50 through 447.60.

**Provider Preventable Conditions**

The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 CFR 434.6(a)(12), 42 CFR 438.6(f)(2), and 42 CFR 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

The Contractor shall <u>not</u> pay a Provider for a Provider Preventable Condition.

The Contractor shall require, as a condition of payment from the Contractor, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by the Contractor and/or EOHHS.

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.

A Contractor may limit reductions in Provider payments to the extent that the following apply:

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

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

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

**Reporting**

The Contractor shall submit to EOHHS all required reports related to the Contract's general administrative requirements, as described in this **Section 2** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

# BEHAVIORAL HEALTH NETWORK RESPONSIBILITIES

## Overview

The Contractor shall establish, operate and manage a Behavioral Health Provider Network to meet the Behavioral Health needs of Covered Individuals. The Contractor shall assure timely access for all Covered Individuals to the full range of BH Covered Services including outpatient, inpatient, 24-hour Diversionary, community Diversionary, and Emergency Services.

The Contractor shall manage its Provider Network in accordance with the Contract between the Contractor and EOHHS, as well as with the terms of its Provider Agreements with the Network Providers in its Behavioral Health Provider Network.

The Contractor shall meet its responsibilities under this Contract while adhering to the following key principles of Behavioral Health Provider Network management:

- The use of data in decision-making;
- Adherence to a continuous quality improvement process between the Contractor and Network Providers that focuses on access, quality, value and Covered Individual outcomes;
- Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions;
- Recognizing the capacity of Covered Individuals and their families to access their strengths as part of their treatment and eventual recovery;
- Supporting and incorporating EOHHS health care reform initiatives, including PCMHI and those associated with payment reform;
- Improving the ability of the Behavioral Health Provider Network to meet all of the health needs of Covered Individuals through strengthened collaboration with PCCs, Emergency departments, specialty medical providers, pharmacies and inpatient hospital providers.

The Contractor shall actively solicit best practice models that achieve and exemplify these principles in its programs and shall submit to EOHHS proposals to establish and replicate such programs.

### Network Development

### Management Strategy

The Contractor shall:

Beginning on the Service Start Date, develop and implement a strategy to manage the Provider Network with an emphasis on the following:

Access to care for Covered Individuals;

Quality of care;

Application of principles of rehabilitation and recovery to service planning and service delivery;

Reduction of health disparities (see **Section 3.1.H)**;

Measurement of outcomes for Covered Individuals over the course of receiving Behavioral Health Covered Services. The outcomes can range across the Covered Individual's full life domain;

Integration of Behavioral Health Covered Service delivery with medical services provided by the Enrollee's PCC or other key health care Providers; and

Cost-effectiveness of the delivery of BH Covered Services.

Ensure that its management strategy includes at least the following:

A systematic plan for utilizing Network Provider profiling and benchmarking data to identify and manage Network Providers who fall below established benchmarks and performance standards, and to replicate practices of Network Providers who consistently exceed benchmarks and performance standards;

A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward improvement goals;

Utilization of on-site visits to Network Providers at all Levels of Care, to support quality improvement efforts and benchmarking data; and

Steps to ensure Network Provider compliance with the Contractor's performance specifications for each BH Covered Service.

Take appropriate management action, including the development and monitoring of corrective action plans for Network Providers whose performance is determined by the Contractor to be in need of improvement.

Take appropriate action related to Network Providers who are also MassHealth Providers, as follows:

Upon the Contractor's awareness of any disciplinary action or sanction taken against a Network Provider, either internally by the Contractor or by any oversight agency or any source outside of the Contractor's organization, such as the Board of Registration in Medicine, the Division of Registration, and the federal Centers for Medicare and Medicaid Services (CMS), immediately inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department of such action taken and work collaboratively with the Customer Services vendor to maintain a process to share such information.

If notified that MassHealth or another state Medicaid agency has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any

such provider from the Medicaid program, review the Provider's performance related to this Contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

In collaboration with and as further directed by EOHHS, develop and implement Network Provider quality improvement activities directed at ensuring that Network Providers:

use the CANS Tool (see **Section 3.5.B**) in their Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services for Covered Individuals under the age of 21; and

access and utilize the CANS IT System to input information gathered using the CANS Tool to identify whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

Propose by the Service Start Date, and implement subject to EOHHS approval, a Network management strategy to engage with PCCs, specialty Providers, high-volume prescribers, and hospital Emergency departments to improve access for Covered Individuals who may be under- or over-utilizing Behavioral Health services. The proposal shall include but is not limited to:

Ways to complement current EOHHS efforts, including the Controlled Substance Management Program, DPH's Prescription Monitoring Program and other programs initiated by the MassHealth Pharmacy Program; and

Methods for the Contractor's staff and its Behavioral Health Network Providers to use to identify Enrollees who may benefit from participation in the Care Management Program described in **Section 6.2**;

Propose methods the Contractor will use to engage foster parents and other individuals with physical custody of Children in the Care and/or Custody of the Commonwealth in such children's health care needs to ensure that they obtain Early and Periodic Screening, Diagnosis and Treatment (EPSDT), periodic and inter-periodic screens and Medically Necessary follow-up medical dental and Behavioral Health services; and

Propose methods the Contractor will use to establish and maintain specific supports for Providers of Behavioral Health, Primary Care, and specialty health care who provide MassHealth Covered Services to Children in the Care and/or Custody of the Commonwealth to ensure continuity of care for Children in the Care and/or Custody of the Commonwealth who change Providers due to changes in their foster care arrangements or for other reasons.

The Contractor's proposal may be accepted, rejected, or modified by EOHHS in whole or in part.

**Establishment of Behavioral Health Provider Network**

As of the Service Start Date, the Contractor shall have in effect and maintain a Network of Providers for the delivery of BH Covered Services set forth in **Appendix A-1**, in accordance with the terms of this Contract. To the extent that any provider in the Contractor's provider network is subject to the Emergency Medical Treatment and Labor Act (EMTALA), it must comply with the Act, which requires:

a. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. 489.24(b).

b. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

The Contractor shall:

Make best efforts to ensure that all network providers from the previous BHP contract continue to participate in the Contractor's Provider Network and, accordingly, renew prior to the Service Start Date Provider Agreements with all such network providers.

Ensure that all Provider Agreements the Contractor initially executes with network providers from the previous BHP contract are for a term of at least one year.

Enter into Provider Agreements with each ESP identified in **Appendix A-3** to provide ESP Services and Youth Mobile Crisis Intervention Services and each Community Service Agency (CSA) identified in **Appendix A-2** to provide Intensive Care Coordination and Family Support and Training Services.

No later than one month prior to the Service Start Date, or as otherwise agreed to by EOHHS, submit to EOHHS for its review and approval the Contractor's initial Provider Network.

Ensure that in the event that network providers contracted with the previous BHP vendor refuse to participate in the Contractor's Network, there are sufficient Network Providers to deliver all BH Covered Services in accordance with the terms of this Contract.

Ensure that its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following Behavioral Health conditions:

Dual Diagnosis;

Serious and Persistent Mental Illness;

Post-traumatic stress disorder, especially among children and adolescents;

Severed Emotional Disturbance (SED) among children and adolescents;

Sex-offending behaviors;

Eating disorders; and

Autism.

Ensure its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following populations of Covered Individuals:

Persons with physical disabilities;

Persons with chronic illness(es);

Children, adolescents and their families;

Persons who are homeless, including children and families;

Children in the Care and/or Custody of the Commonwealth;

Young adults who are transitioning out of state-sponsored programs as they turn 22;

Persons with developmental disabilities;

Persons with brain injuries;

Persons with HIV/AIDS;

Pregnant women who are substance abusers;

Young children;

Older adults;

Persons from diverse cultural backgrounds, including persons whose primary language is not English;

Persons who are deaf or hard of hearing; and

Persons who are blind or visually impaired.

Provide coverage across all regions of the state.

Ensure the availability of the full range of BH Covered Services.

Provide access to BH Covered Services according to the standards set forth in Section 3.1.G.

Make best efforts to ensure that women- and minority-owned or -controlled agencies and organizations are represented in the Provider Network, and submit to EOHHS an annual written assessment of the results of such efforts each Contract Year.

In establishing the Provider Network, consider the following:

The anticipated MassHealth enrollment for Covered Individuals;

The expected utilization of services, taking into consideration the characteristics and health care needs of specific MassHealth populations enrolled with the Contractor;

The numbers and types (in terms of training, experience, and specialization) of Network Providers required to furnish the BH Covered Services;

The numbers of Network Providers who are not accepting new Covered Individuals; and

The geographic location of Network Providers and Covered Individuals, considering distance, travel time, the means of transportation ordinarily used by Covered Individuals, and whether the location provides physical access for Covered Individuals with disabilities. (See also **Section 3.1.G.**)

At its discretion, create a plan, subject to EOHHS review and approval, to selectively procure a Provider Network.

Ensure that such plan provides for procuring the Network in a fair and equitable manner, and in accordance with the requirements set forth in **subsections 12.a-e**, above.

Allow all interested providers, including independently practicing licensed social workers, licensed mental health counselors Licensed Alcohol and Drug Counselors 1 (LADC1), and licensed marriage and family therapists, to apply to become Network Providers.

Submit to EOHHS for review and approval the new Provider Network following a reprocurement.

Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the ESP Provider network prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals or Uninsured Individuals or persons with Medicare only.

Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the list of CSAs prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with

the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals.

Ensure the following payment provisions are met:

i. Payments to Federally Qualified Health Centers (FQHCs) for services to Covered Individuals are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay to Federally Qualified Health Care Centers with which it contracts at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 114.3 CMR 6.03, excluding any supplemental rate paid by MassHealth to FQHCs.

ii. If the amount paid by a managed care entity to an Indian Health Care Provider that is not a Federally Qualified Health Center for services provided by the provider to an Indian Enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian Health Care Provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

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 in an amount equal to at least 101 percent of allowable costs under the Contractor's plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services

In Contract Year 2, the Contractor shall provide an aggregate rate increase totaling not less than Five Million Dollars ($5,000,000.00) to Network Providers. Such rate increases shall be effective no later than January 1, 2014. By April 15, 2014, the Contractor and EOHHS shall agree on a method of validating that the Contractor has established and is paying such increased rates. The Contractor shall take corrective action measures approved by EOHHS if EOHHS determines rate increases have not been implemented in accordance with this section.

In the initial procurement of ESP services for the Southeast Area:

(a) the Contractor shall issue a Request for Proposal (RFP) to procure ESP services for the Southeast;

(b) the Contractor will select winning bidders;

(c) at the direction of EOHHS, the Contractor shall execute provider agreements with each winning bidder for the Southeast Area that require providers to:

(i) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:
1. provided ESP services; and

2. were terminated as a result of DMH ceasing to provide such ESP services.

(ii) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees.

(iii) pay wages to those hired in accordance with this section that are not less than the minimum wage rate for those positions for which the duties are substantially similar to the duties performed by regular agency employees, as follows:

| ESP Core Staffing Position | Substantially Comparable DMH Position | Minimum Wage Rate under MGL c.7 §54(2) | Suggested Salary for Positions not comparable to DMH Positions |
|---|---|---|---|
| ESP Director | Clinical Social Worker (D) | $62,202.14 | |
| ESP Director | Psychologist IV | $77,085.06 | |
| QM/ RM Director | Manager VI | $57,071.04 | |
| Program Manager | Clinical Social Worker (D) | $62,202.14 | |
| Clinical Supervisor | Clinical Social Worker (C) | $59,511.60 | |
| Clinical Supervisor | Human Services Coordinator (D) | $56,612.40 | |
| Psychiatry | N/A | | $221,700.00 |
| Psychiatry After-Hours Adult Consult | N/A | | $67,500.00 |
| Psychiatry After-Hours Child Consult | N/A | | $67,500.00 |
| Nursing Manager RN | Registered Nurse IV | $62,751.26 | |
| Nursing Manager RN | Registered Nurse V | $68,265.34 | |
| Nursing RN | Registered Nurse II | $57,395.26 | |
| Nursing RN | Community Psychiatric Mh Nurse | $62,751.60 | |
| Nursing LPN | Licensed Practical Nurse I | $40,513.20 | |
| Nursing LPN | Licensed Practical Nurse II | $42,955.38 | |
| Certified Peer Specialist | Mental Health Coordinator I | $44,380.18 | |
| BS w/CPS preferred | Human Services Coord (A/B) | $48,911.10 | |
| BS Milieu | Mental Health Worker I | $30,146.74 | |
| BS Milieu | Mental Health Worker II | $32,262.62 | |
| BS Milieu w/CPS pref. | Human Services Coord (A/B) | $48,911.10 | |
| Paraprofessional (Family Partner) | Mental Health Coordinator I | $44,380.18 | |
| MS Triage Clinician | Human Services Coordinator (C) | $53,934.40 | |
| MS Triage Clinician | Social Worker (C) | $51,539.80 | |
| MS Clinicians | Human Services Coordinator (C) | $53,934.40 | |
| MS Clinician Mobile | Human Services Coordinator (C) | $53,934.40 | |
| MS Clinician Mobile | Clinical Social Worker (A/B) | $53,934.40 | |
| MS Clinician Mobile | Clinical Social Worker (C) | $59,511.60 | |
| Safety Staff | Mental Health Worker I | $30,146.74 | |
| Admin. Assistant | Administrative Assistant I | $40,405.15 | |
| Admin. Assistant | Clerk III | $33,460.70 | |

(iv) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons.
(v) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

**Contract Provisions of Behavioral Health Provider Network**

The Contractor shall:

Effective January 1, 2014, the Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for Behavioral Health Covered Services as most recently adopted by the American Medical Association and CMS; and shall pay no less than the MassHealth rate for such CPT codes. Except as otherwise provided in this Contract, develop proposed Network Provider payment rates for all services;

Unless otherwise agreed to by EOHHS, inform EOHHS of proposed rate changes prior to implementing them, executing Provider Agreements, or entering into any other arrangements with Network Providers;

Execute and maintain for the term of the Contract written Provider Agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified Network Providers to provide Covered Individuals with all Medically Necessary BH Covered Services;

Prior to distributing or executing any Provider Agreements or any amendments thereto, submit standard language for any such Agreement to EOHHS for approval;

Ensure that all Provider Agreements include provisions:

requiring Network Providers to accept as payment in full the Contractor's payment for BH Covered Services provided to Covered Individuals;

prohibiting Network Providers from charging Covered Individuals in full or in part for any service provided under the Contract or imposing any financial penalties on them, including charges for canceling or missing appointments, and as further set forth in **Section 2.3.E**;

stating the following:

"Providers shall not seek or accept payment from any Covered Individuals for any BH Covered Service rendered, nor shall providers have any claim against or seek payment from EOHHS. Instead, providers shall look solely to the (Contractor's name) for payment with respect to BH Covered Services rendered to Covered Individuals. Furthermore, providers shall not maintain any action at law or in equity against any Covered Individuals 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 subcontractor and where "provider" refers to the subcontractor, including Network Providers and non-Network Providers with whom the Contractor is contracting)."

notwithstanding the provisions of subsections **5.a** and **b**, requiring Network Providers to charge Covered Individuals copayments in accordance with EOHHS's copayment regulations, at the direction of EOHHS;

prohibiting Network Providers from denying any BH Covered Service to a Covered Individual for failure or inability to pay any charge, or to a Covered Individual who, prior to becoming eligible for MassHealth services, incurred a bill that has not been paid;

requiring any Network Provider to notify the Contractor if it has reason to be considering insolvency or is otherwise financially unsound. The Contractor shall notify EOHHS within one business day of receipt of such financial notification;

requiring Network Providers of mental health Inpatient Services to accept for admission all Covered Individuals in need of inpatient admissions who are referred by ESPs, regardless of the availability of insurance, capacity to private pay, or clinical presentation;

prohibiting Network Providers from engaging in any practice with respect to any Covered Individual that constitutes unlawful discrimination on the basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulation, including but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

requiring Network Providers to collaborate with EOHHS health care reform initiatives, including but not limited to payment reform and the Patient-Centered Medical Home Initiative, as directed by the Contractor.

clearly stating the Provider's EMTALA obligations and are not creating any conflicts with hospital actions required to comply with EMTALA.

As directed by EOHHS, ensure that all Provider Agreements with Network Provider clinicians who provide Behavioral Health services to Covered Individuals under the age of 21 in certain Levels of Care (including Diagnostic Evaluation for Outpatient Therapy (Individual Counseling, Group Counseling, and Couples/Family Counseling), Inpatient Psychiatric Services, and Community-Based Acute Treatment Services) require that they:

Become certified in the use of the Child and Adolescent Needs and Strengths (CANS) Tool for Behavioral Health diagnostic evaluations (see also **Section 3.5**), and recertified in its use every two years;

Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for a Covered Individual under the age of 21, which shall include using the CANS Tool during initial Behavioral Health Clinical Assessments and, at a minimum, every 90 days thereafter during ongoing treatment, and also as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services as described in **Appendix A-1**; and

Subject to consent, if required, by the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and the determination whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

Clinicians covered by this requirement include psychiatrists, psychiatric nurse mental health clinical specialists, psychologists, licensed independent clinical social workers (LICSWs), licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), and unlicensed master's-level clinicians working under the supervision of a licensed clinician. If EOHHS determines that other types of clinicians who provide Behavioral Health Covered Services to Covered Individuals under the age of 21 in additional Levels of Care are also subject to the provisions of this section, the Contractor shall also include these provisions in such clinicians' Network Provider Agreements, as directed by EOHHS.

Ensure that all Provider Agreements with Community Service Agencies require that all intensive care coordinators of all levels:

Become certified in the use of the CANS Tool and recertified every two years;

Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of intensive care coordination and, at a minimum, every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from the Intensive Care Coordination service; and

Subject to consent by the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, enter into the CANS IT System the information gathered using the CANS Tool and the intensive care coordinator's determination of whether the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

When requested, provide for a second opinion from a qualified health care professional within the Provider Network or arrange for the Covered Individual to obtain one outside the Provider Network, if a qualified in-

network health care professional is not available, at no cost to the Covered Individual;

Ensure that its Network Providers comply with state and federal regulations that prohibit a health care facility from charging or seeking payment for services provided as a result of the occurrence of certain Serious Reportable Events, as well as any additional requirements or limitations placed on payment by EOHHS;

Ensure that its Provider Agreements specify that:

No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition; and

As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor.

**Contract Provisions for Network Providers that Perform Behavioral Health Clinical Assessments**

The Contractor shall:

Require of all Network Providers that have clinicians who provide Behavioral Health Clinical Assessments and conduct Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7,** that they have Virtual Gateway accounts and a high-speed internet or satellite internet connection to access the CANS IT System; except that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers of these requirements on a case-by-case basis.

Require of all Network Providers that provide Behavioral Health Clinical Assessments and perform Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7**, that they seek consent from the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, using the form of consent approved by EOHHS, before entering the information gathered using the CANS Tool into the CANS IT System.

Require Network Providers that obtain such consent to enter the information gathered using the CANS Tool and the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

Require Network Providers that do not obtain such consent to enter only the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

**Health Care Reform, Including Payment Reform**

The Contractor shall collaborate with EOHHS upon request on the development and implementation of payment reform initiatives for its Network Providers. Such initiatives may include

Global payments rather than Fee-for-Service payments;

Primary Care Payment Reform initiatives;

Pay for Performance; and

Other outcome-based payment methods.

**Non-Network Providers**

The Contractor shall:

Permit Covered Individuals who reside in a rural service area, as identified by EOHHS in accordance with the provisions of 42 CFR 412.62(f)(1)(ii) (currently, Dukes County and Nantucket County), to obtain Medically Necessary BH Covered Services from non-Network Providers under the following circumstances:

The Covered Individual is unable to obtain the same service or to access a Network Provider with the equivalent training, experience, and specialization within the Provider Network;

The Network Provider from whom the Covered Individual seeks the service is the main source of service to the Covered Individual, except that the Covered Individual shall have no right to obtain services from a Provider outside the Provider Network if the Contractor gave the Provider the opportunity to participate in the Provider Network under the same requirements for participation applicable to other Providers and the Provider chose not to join the Provider Network or did not meet the necessary requirements to join the Provider Network;

The only Network Provider available to the Covered Individual in the Provider Network does not, because of moral or religious objections, provide the service the Covered Individual seeks; or

The Covered Individual's Network Provider or other provider determines that the Covered Individual needs a service(s), and that the Covered Individual would be subjected to unnecessary risk if he/she received the needed services separately and not all of the related services are available within the Provider Network.

Adequately and timely provide all Covered Individuals with access to non-Network Providers for BH Covered Services for as long as the Contractor is unable to provide them. The Contractor shall negotiate and execute written single-case agreements or arrangements with non-Network Providers, when necessary, to assure access to BH Covered Services.

Ensure that non-Network Providers' agreements or arrangements include the provisions required in **Section 3.1.C.4**.

Ensure that service authorizations and Utilization Management protocols, Claims submissions and Internal Appeals policies for non-Network Providers are consistent with the terms in the Contractor's Network Provider Agreements.

**Access and Availability of Behavioral Health Provider Network**

The Contractor shall:

Permit Covered Individuals to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Covered Services.

Ensure adequate physical and geographic access to BH Covered Services for Covered Individuals.

Ensure Covered Individuals have access to a choice of at least two Network Providers who provide BH Covered Services to the extent that qualified, willing Network Providers are available.

Assure EOHHS that it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in **Sections 3.1.G.6** and **7** by submitting reports specified in **Appendix E-1**, on a quarterly basis and whenever there is a significant change in operations that would affect the adequacy and capacity of services. "Significant changes" include, but are not limited to:

changes in MassHealth Covered Services;

enrollment of a new population in the Contractor's plan;

changes in benefits; and

changes in Network Provider payment methodology.

If the Contractor does not comply with the access standards specified in **Sections 3.1.G.6** and **7**, the Contractor shall take corrective action necessary to comply with such access standards.

Ensure access to BH Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that physical and communication barriers do not inhibit them from obtaining services under the Contract.

Monitor the practice of creating waiting lists for Covered Individuals who seek outpatient BH Covered Services. If the Contractor determines that a Network Provider has established a waiting list, the Contractor shall create a plan to identify such Network Providers and help them reduce such waiting lists, with the goal of eliminating them. Such activity shall include but not be limited to the Contractor directly assisting Covered Individuals

to find an appropriate alternative Provider. The Contractor shall further ensure that:

Waiting lists are established and maintained in such a way as to not violate the provisions of M.G.L. c. 151(B), including waiting for appointments after the initial appointment; and

Network Providers with waiting lists refer Covered Individuals to other qualified Network Providers who do not have waiting lists.

Execute and maintain Provider Agreements with Network Providers to ensure that, at a minimum, 90 percent of Covered Individuals have access to all Medically Necessary Behavioral Health Covered Services according to the following standards:

Inpatient Services within 60 miles or 60 minutes' travel time from the Covered Individual's residence, whichever requires less travel time;

ESP Services as available based on the ESP Provider list in **Appendix A-3**; and

Intensive Care Coordination and Family Support and Training Services provided by Community Service Agencies as available based on the CSA Provider list in **Appendix A-2**;

Other Intensive Home and Community-Based Services, which require Network Providers to travel to the Covered Individual's residence for services, must be available in all cities and towns in the Commonwealth; and

All other BH Covered Services within 30 miles or 30 minutes' travel time from the Covered Individual's residence, whichever requires less travel time.

Notwithstanding the generality of the foregoing, the Contractor shall ensure access to at least one Network Provider, except ESPs, of each BH Covered Service in every geographic region of the state with more than 2.5 percent of Covered Individuals or, as determined by EOHHS, to the extent that qualified, interested Providers are available.

Ensure that access to Behavioral Health Services for Covered Individuals is consistent with the degree of urgency, as follows:

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

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

Urgent Care Services shall be provided within 48 hours; and

All other care shall be provided within 14 calendar days.

Offer Covered Individuals who require readmission to Inpatient Mental Health Services readmission to the same Network Provider when there is a bed available in that facility.

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

The Contractor may request an exception to the access standards set forth in this **Section 3.1.G** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to or better than the usual and customary community standards for accessing care. Upon approval by EOHHS, the Contractor shall notify Covered Individuals in writing of such alternative access standards.

**Health Disparities**

The Contractor shall ensure that:

Multilingual Network Providers and, to the extent that such capacity exists in a region, all Network Providers understand and comply with their obligations under state and federal law to assist Covered Individuals with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

Network Providers and interpreters/translators are available for those who are deaf or hearing-impaired, to the extent that such capacity exists within each region.

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

Perform at the beginning of the Contract, and thereafter at least every three years, an in-depth demographic analysis with Network Providers, as well as more robust data analysis, to identify health disparities and develop mitigation strategies based on current Network Provider capacity as described in subsections **1-3**, above; and build additional Network capacity based on the analysis.

Implement the identified mitigation strategies as approved by EOHHS.

**Network Provider Credentialing**

Credentialing Process

The Contractor shall implement written policies and procedures that comply with the EOHHS requirements set forth below regarding the selection, retention, and exclusion of

Providers from the Provider Network. Such written policies and procedures shall, at a minimum:

Require Network Providers to meet the Credentialing Criteria approved by EOHHS, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**.

Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Network Providers and all other licensed or certified Network Providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by 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. The basic components of these processes shall include a review of the following:

licensing, accreditation, certification, training, specialty board eligibility or certification;

current status of professional license, restrictions, and history of any loss of licensure in any state;

DEA number and copy of certification, where applicable;

hospital privileges, name of hospitals, and scope of privileges, where applicable;

malpractice insurance, carrier name, amount of coverage, copy of the face sheet, and scope of coverage;

malpractice history, pending claims, and successful claims against the Provider;

record of continuing professional education;

Medicare, Medicaid, federal tax identification number, and Social Security numbers;

location, service area and telephone numbers of all offices, hours of operation, and provisions for Emergency care and backup;

areas of special experience, skills and training;

cultural and linguistic capabilities;

review of Covered Individual satisfaction and any complaints made or Grievances filed against the Network Provider within the past two years;

physical accessibility for persons with disabilities;

reference check;

for facility-based Network Providers, a site visit and evidence of a training program for staff on the appropriate and safe use of restraint and seclusion to the extent that the facility's license permits the use of seclusion;

for Network Providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

Ensure that all Network Providers are credentialed prior to becoming Network Providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations;

Ensure that physician Network Providers and other licensed or certified professional Network Providers maintain current knowledge, ability, and expertise in their practice area(s) by, at minimum, obtaining continuing education units (CEUs) and participating in other training opportunities, as appropriate.

Ensure that Network Providers are recredentialed every three years, at a minimum, and take into consideration various forms of data, but not limited to, Grievances, results of quality reviews, Covered Individual satisfaction surveys, and Utilization Management information.

Designate the Contractor's department(s) and staff who will be directly responsible for credentialing and recredentialing Network Providers.

To the extent permitted by law and upon request, provide Covered Individuals or their legal guardians with information in the Network Provider database, with the exception of the information described in subsections **b.5)**, **6)**, **8)**, **14)**, **15)** and **16)** above.

Ensure that that the credentialing process does not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

Not authorize any Network Providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Covered Individuals, and deny payment to such Network Providers for any service provided.

The Contractor shall, at a minimum, check the BORIM website at least once per month and the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individuals Entities (LEIE) or Medicare Exclusion Database (MED) websites before the Contractor contracts with a Provider to become part of its Provider Network, at the time of a Provider's credentialing and recredentialing, and at least monthly.

The Contractor shall notify a Network Provider within three business days that, due to its MassHealth, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such Network Provider is terminated or suspended, as appropriate, from the Contractor's Provider Network, and is no longer eligible to treat Covered Individuals. The Contractor shall have a process in place to immediately effectuate such termination or suspension.

When the Contractor terminates, suspends, or rejects a Network Provider from its Network based on such Provider's termination or suspension with MassHealth, Medicare, or another state's Medicaid program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify EOHHS of the Network Provider termination, suspension or rejection, and the reason thereof, within three business days.

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

This section does not preclude the Contractor from suspending or terminating Network Providers for cause prior to such Network Provider's ultimate suspension and/or termination by EOHHS from participation in MassHealth.

Not contract with a Provider, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs by the OIG under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901.

Ensure that no Network Provider engages in any practice with respect to any Covered Individual that constitutes unlawful discrimination under any other state or federal

law or regulation, including but not limited to practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

Search for the names of parties disclosed during the credentialing process in the BORIM, OIG LEIE, and Medicare MED exclusion or debarment databases and the MassHealth exclusion list, and do not contract with parties that have been terminated from participation under Medicare or another state's Medicaid program.

Notify EOHHS when a Network Provider fails credentialing or re-credentialing because of a program-integrity reason, including those reasons described in this **Section 3.1.I.1**, and provide information required by EOHHS or state or federal laws, rules, or regulations.

Demonstrate to EOHHS, by reporting annually in accordance with **Appendix E-1**, that all Network Providers within the Contractor's Provider Network are credentialed according to this **Section 3.1.I.1**.

Network Provider Qualifications

The Contractor shall:

Execute Provider Agreements or enter into other arrangements for BH Covered Services only with facility-based Providers that satisfy the following criteria:

They are financially stable, as determined by the Contractor;

They have established and maintain a Quality Management program, as described in **Section 8**;

They comply with policies and regulations with respect to patient rights and privileges, as applicable;

They maintain records consistent with current professional standards and EOHHS regulations, as well as systems for accurately documenting the following information for each Covered Individual receiving BH Covered Services:

demographic information;

clinical history;

Behavioral Health Clinical Assessments;

treatment plans;

services provided;

contacts with Covered Individuals' family, guardians, or significant others; and

treatment outcomes;

Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial or linguistic minority, or other special population in the region in which they provide services;

Have the capacity to communicate with Covered Individuals in languages other than English, when necessary, as well as with those who are deaf or hearing-impaired;

Satisfy all federal and state requirements for affirmative action;

Satisfy all federal and state legal requirements regarding the Provider's physical plant and premises;

Comply with all applicable anti-discrimination requirements described in 42 CFR 438.6(d)(3) and (4);

Comply with all other applicable state and federal laws;

Meet the Credentialing Criteria, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**; and

Have been credentialed pursuant to the policies and procedures specified in **Section 3.1.I.1**.

Ensure that, in addition to the criteria set forth in subsection **a**, above, those facility-based Network Providers that are Network Providers of Inpatient Services are fully licensed by DMH and by DPH as applicable. In addition, ensure that such Providers:

Comply with DMH regulations concerning human rights set forth in 104 CMR 27.13 and 14 and 104 CMR 28.11, including ensuring that that human rights activities are overseen by a human rights committee and officer, and provide training for staff and education for Covered Individuals regarding human rights. To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

Comply with DMH's regulations concerning restraint and seclusion (see **Section 3.2.A**, below). To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

Submit to the Contractor evidence of implementation of the training programs described in subsections **b.2)** and **3)** as part of investigations of Serious Reportable Events, implementation of corrective action plans that involve human rights, and the use of restraint and seclusion;

Notify the DMH Licensing Unit of an inpatient Provider's non-compliance with these requirements and collaboratively determine whether additional Contractor action is appropriate; and

Develop organizational and clinical linkages with each of the high-volume referral source ESPs, as identified by EOHHS, hold regular meetings, and communicate with the ESPs on clinical and administrative issues, as needed, to enhance continuity of care for Covered Individuals;

Contractor activities to ensure compliance include informing the DMH Licensing Unit of inpatient units' non-compliance with these requirements and collaboratively determining if additional action by the Contractor is appropriate.

Preferentially execute Provider Agreements or enter into other arrangements for the provision of BH Covered Services with Providers that demonstrate a commitment to the principles of rehabilitation and recovery from mental illness and addiction, including a focus on recovery-oriented services, consumer and family involvement in program management, a strength-based approach to working with children and their families, and training for staff on such principles.

Credentialing Waiver Process

The Contractor shall:

Develop a proposal for a credentialing waiver process to allow certain Providers who do not meet all of the Contractor's Credentialing Criteria to be included in the Provider Network when there is an objective need for including those Providers (e.g., the Provider fills a cultural, linguistic, or geographic access need).

Ensure that no BH Covered Service is rendered at any time during the term of the Contract by any person, facility, agency or organization that does not meet all Credentialing

Criteria under this Contract, or any applicable law or regulation, unless EOHHS specifically waives in writing an applicable Credentialing Criterion, to the extent such waiver is within the authority of EOHHS.

### Additional Behavioral Health Provider Network Requirements

**Use of Restraint and Seclusion Techniques**

The Contractor shall require Network Providers to have all applicable licenses and comply with all applicable laws and regulations concerning restraint and seclusion, including without limitation:

DMH regulations concerning seclusion and restraint at 104 CMR 27.12 and physical restraint at 104 CMR 28.05, or any successive regulation; and

Federal regulations at 42 CFR 441.151 subpart D and 42 CFR 483 subpart G.

The Contractor shall monitor the Network Providers' compliance with the requirements of the laws and regulations set forth by DMH, as well as all other applicable laws and regulations.

To the extent permissible under **Section 14**, the Contractor shall notify EOHHS and the DMH Licensing Unit of non-compliance; and

The Contractor shall take all necessary corrective actions to correct non-compliance by Network Providers in collaboration with the DMH Licensing Unit.

**Linkage with Consumer Initiatives, Recovery Initiatives, Natural Community Supports and Anonymous Recovery Programs**

The Contractor shall manage the Behavioral Health Provider Network to align with other programs and services that support and complement Covered Individuals' participation in BH Covered Services and that promote Covered Individuals' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes.

The Contractor shall actively manage Network Providers to complement and integrate with the following formal and informal resources and programs:

Consumer Initiatives;

Rehabilitation programs that promote skill-building, supported employment and full competitive employment for Covered Individuals;

Natural community supports for Covered Individuals and their families; and

Anonymous recovery programs (e.g., 12-step programs) for Covered Individuals and their families.

The Contractor shall also work with its Network Providers to actively collaborate with other EOHHS-funded programs, including but not limited to:

DMH-funded programs, such as Community-Based Flexible Supports;

DCF-funded programs that support the safety, permanency and well-being of Children in the Care and Custody of the Commonwealth;

BSAS-funded programs for Covered Individuals, such as recovery homes to promote continuity of services for substance abuse from acute care to supportive and rehabilitative care and recovery supports;

DDS programs that involve rehabilitative and habilitative services for persons with developmental disabilities;

DYS programs that help clients stay in the community and avoid recidivism to DYS;

Other programs and initiatives within EOHHS, MassHealth and DPH related to PCC coordination and pharmacy management, including federal and state grant programs; and

Prevention and wellness programs at the state, regional and local level.

The Contractor shall demonstrate through its Network management plan and individual Network Provider Agreements the continued effort to work with Network Providers to access these resources and supports.

**Compliance with Section 1202 of the ACA and 42 U.S.C 1396a(13)(C)**

This **Section 3.2.C** implements Section 202 of the Affordable Care Act (ACA).

In the event that this Contract provides for payment of Primary Care services or vaccine administration, as defined in said Section 1202 and related regulations and subregulatory guidance, then the Contractor shall comply as follows:

As directed by EOHHS, and for services rendered on or after January 1, 2013, the Contractor shall set payment rates for primary care services provided by eligible Providers and for pediatric vaccines in accordance with Section 1202 of the ACA and 42 U.S.C. 1396a(13)(C), EOHHS policies, and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. In the manner and frequency directed by EOHHS, the Contractor shall submit reports relating to this **Section 10.1.A.6**.

Notwithstanding the generality of the foregoing, the Contractor shall, in accordance with 42 CFR 438.6(c)(5)(vi), for payments for primary care services in calendar years 2013 and 2014 furnished to Enrollees under 42 CFR Part 447, subpart G:

1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 CFR Part 447, subpart G; and

2. Provide documentation to EOHHS, sufficient to enable EOHHS and CMS to ensure that provider payments increase as required by subsection 1.

**Compliance with Federal BBA Requirements**

**Subcapitation and Physician Incentive Plans**

The Contractor may, subject to EOHHS's prior review and approval and all applicable state and federal rules and regulations, including but not limited to the provisions of 42 CFR 438.6(h), 42 CFR 422.208 and 422.210, negotiate and enter into arrangements to pay Network Providers on a subcapitated basis or operate a physician incentive plan.

The Contractor shall not engage in risk-sharing payment methodologies (i.e., non-Fee-for-Service arrangements) with its Network Providers without first submitting the proposed payment methodology to EOHHS for review and approval. Any Network Provider payment methodology that the Contractor proposes to EOHHS must satisfy the following minimum requirements:

Balance cost incentives with access and quality incentives; and

Ensure that those Network Providers for whom the Contractor proposes to use such payment methodologies are able to demonstrate the managerial, operational and financial capability to manage the proposed risk arrangement.

The Contractor shall comply, and shall ensure that its subcontractors comply, with all applicable requirements governing subcapitation arrangements and physician incentive plans. In accordance with the requirements of 42 CFR Parts 417, 434 and 1003, the Contractor shall ensure that:

No specific payment is made directly or indirectly to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Covered Individual; and

The applicable stop-loss protection, Covered Individual survey, and disclosure requirements of 42 CFR Part 417 are met.

**Emergency and Post-stabilization Care Service Coverage**

The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition in accordance with 42 CFR 438.114 and M.G.L. c. 118E, § 17A.

The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition regardless of whether the Provider that furnishes the services has a contract with the Contractor.

The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition, including cases in which the absence of immediate medical attention would not have:

placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

resulted in serious impairment to bodily functions; or

resulted in serious dysfunction of any bodily organ or part.

The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition if a representative of the Contractor instructed the Covered Individual to seek Emergency services.

The Contractor may not limit what constitutes a Behavioral Health Emergency medical condition on the basis of lists of diagnoses or symptoms;

The Contractor may require Network Providers to notify the Covered Individual's PCC of the Covered Individual's screening and treatment, but may not refuse to cover MassHealth Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition based on their failure to do so;

A Covered Individual who has an Emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient;

The attending emergency physician, or the Provider actually treating the Covered Individual, is responsible for transfer or discharge, and that determination is binding on the Contractor, if such transfer or discharge order:

is consistent with generally accepted principles of professional medical practice; and

is a covered benefit under the Contract.

The Contractor shall cover and pay for Post-stabilization Care Services that are MassHealth Covered Services in accordance with 42 CFR 438.114, 42 CFR 422.113(c), and M.G.L. c. 118E, § 17A.

**Non-Network Emergency Service Coverage**

The Contractor shall pay a non-Network Provider of Emergency Services an amount equal to the amount allowed under the state's Fee-for-Service rates less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Covered Individual is not balance billed for the difference, if any, between such rate and the non-Network Provider's charges.

**ESP Services**

**ESP Policies and Procedures**

For ESP Providers under contract with the Contractor, the Contractor shall:

Ensure that the ESP Providers set forth in **Appendix A-3** provide all ESP Services as set forth in **Appendix A-1**, consistent with the Contractor's performance specifications;

Ensure that Covered Individuals and Uninsured Individuals and persons covered by Medicare only are provided with unrestricted access to ESP Services, including Adult and Youth Mobile Crisis Intervention, immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week;

Ensure that the response time for face-to-face evaluations by ESPs does not exceed one hour from notification of the need, or, in the case of referrals from hospital emergency departments, from the notification of readiness for evaluation by the ESP;

Ensure the 24-hour-a-day access or availability of clinicians in the ESPs who have special training or experience in providing Behavioral Health services for:

the full array of Behavioral Health conditions;

children and adolescents (clinicians providing ESP Services to children and adolescents must be child-trained clinicians who meet Youth Mobile Crisis Intervention competency standards as defined in the Contractor's performance specifications);

individuals with substance abuse disorders or a Dual Diagnosis;

individuals with intellectual disabilities, developmental disabilities, or autism spectrum disorders; and

the elderly.

Establish policies and procedures to ensure that ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals prior to hospital admissions for Inpatient Mental Health Services to ensure that the Covered Individuals have been evaluated for diversion or referral to the least restrictive appropriate treatment setting. The Contractor's policies and procedures shall include:

requiring that the ESP located in the geographic area where the individual is physically located perform the Crisis Assessment and Intervention;

not requiring ESPs to obtain prior authorization to provide a Crisis Intervention and Assessment;

developing Contract standards, reviewed and approved by EOHHS annually, and monitoring the ESP Provider network's performance on diversion and inpatient admission rates, timeliness of assessment, and rate of community-based Emergency Encounters by establishing minimum standards and target/goals for diversionary rates; and

authorizing Medically Necessary BH Covered Services following a Crisis Assessment and Intervention.

Require and ensure that ESPs have arrangements, agreements or procedures to coordinate care with Network Providers, DMH area and site offices, DCF regional offices and DYS regional offices in the geographic area they serve;

For children and adolescents, have in place the following the ESP policies and procedures:

Ensure that each ESP has policies and procedures that include Youth Mobile Crisis Intervention Service;

Ensure that each ESP has arrangements with the major providers of children's residential services in the DMH, DCF, and DYS systems, as identified by the relevant agency's director for the applicable ESP service area; and

Require ESPs to arrange for Specialing Services, when children or adolescents are awaiting admission to a 24-hour Level of Care in a hospital Emergency Department setting, if such services are Medically Necessary to ensure safety when a youth is at risk of harming self or others. Specialing Services are a professional service provided by appropriately credentialed staff. For payment purposes, the Contractor shall not treat such Specialing Services as an ESP Encounter. If an overnight stay is required while the provider is searching for an inpatient bed, the Contractor shall consider requests from the ESP or Mobile Crisis Intervention (MCI) Provider, in consultation with the ED, for authorization to board the Covered individual on a pediatric medical unit.

Require and ensure that ESPs make all reasonable attempts to work with local police to develop models of mutual response to Behavioral Health Emergencies when needed.

**Payment**

The Contractor shall enter into or amend contracts with ESP Providers, using the ESP Provider rates set by DHCFP as the minimum rate.

**ESP Administrative Oversight**

The Contractor shall coordinate the administration and management of the ESP services for the Contractor's contracted ESP Providers under guidance from DMH and EOHHS. In this role the Contractor shall:

Ensure that all ESP Provider Agreements require ESPs to provide the services described in **Appendix A-1, Part III** to any individual who presents for such services in the following payer categories:

MassHealth (PCC Plan; MassHealth MCOs; FFS),

Commonwealth Care,

Uninsured Individuals, and

Medicare.

Facilitate annually, at least 10 in a 12-month Contract Year, or monthly if the Contract Year is less than 12 months, statewide meetings with Contractor-contracted ESP or MCI providers, and invite the participation of the DMH-operated ESP/MCI providers, to support consistency in service delivery.

Require ESPs to refer adult Uninsured Individuals and persons with Medicare-only to available beds in psychiatric units of general hospitals first, if beds in such hospitals are available and clinically appropriate, before referring them to psychiatric hospitals;

After a court clinician has conducted a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e), ensure that upon request of such court clinician:

ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals (including onsite mobile evaluations at the court).

Identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions. Nothing in this provision shall be construed as establishing a court clinician evaluation as a prerequisite to an onsite mobile evaluation at the court; and

If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), ESPs conduct a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order. If a bed is not found by 4:00, the ESP will work with the court clinician to ensure appropriate disposition and transfer of the individual to a safe place outside of the court setting.

Adopt the existing Massachusetts Behavioral Health Access System, or develop and implement its own process that helps ESPs and hospital Emergency departments to search on-line for available Inpatient Mental Health Services Inpatient Substance Abuse Services, 24-hour Diversionary Services and CBHI Services.

The system shall provide on-line web access on a 24-hour basis seven days a week.

The Contractor shall ensure that the web-based system is updated at least once every eight hours for 24-hour services, and at least weekly for CBHI Services (Intensive Care Coordination, In-Home Behavioral Services, Therapeutic Mentoring, In-Home Therapy).

The Contractor shall develop an annual report (with specifications subject to EOHHS review and prior approval) that tracks utilization of the Massachusetts Behavioral Health Access System and other data as agreed to by the parties.

Encounter Forms

The Contractor shall:

Create an ESP Encounter form to report on ESP Services described in **Appendix A-1**;

Require ESPs to complete and submit the electronic EOHHS-approved ESP Encounter form for each individual they serve; and

Work with EOHHS to transfer the records from the existing Encounter database, which includes the information contained in the ESP Encounter forms.

**Children's Behavioral Health Initiative (CBHI)**

**CBHI Training and Quality Improvement**

The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to improve the CBHI, which shall include, without limitation, participation in meetings and workgroups, including joint workgroups with all MassHealth Managed Care payers to develop coordinated network management and quality improvement strategies for all payers on these services and other tasks as directed.

With EOHHS approval, the Contractor may secure consultant resources to support ongoing implementation, training and quality improvement of CBHI Services. Such consultant resources may recommend network management, Utilization Management and Quality Management strategies or identify strategies to improve the quality of Network Provider organizations in their delivery of CBHI Services. Consultants may also provide trainings or coaching to Providers of CBHI Services, including to providers within the networks of MassHealth Managed Care entities who provide CBHI Services, or perform outreach and education to prospective families in need of CBHI Services.

**Use of the CANS Tool**

The Contractor shall ensure the continued use of the CANS Tool by all Behavioral Health Service providers that are required to use it (see **Section 3.1.C.6**), as directed by EOHHS. The Contractor shall:

Propose for EOHHS approval rates for initial Behavioral Health Clinical Assessments using the CANS Tool for Covered Individuals under the age of 21; Contractor shall allow Network Providers to bill two units of this service to allow for the additional time required to complete this type of evaluation.

Ensure that it pays only Network Providers whose servicing clinicians are certified in the CANS Tool for providing Behavioral Health Clinical Assessments using the CANS Tool;

Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments. The review and updating of the CANS assessment that is required at a minimum every 90 days for Covered Individuals in ongoing individual, group, or family therapy is part of the treatment planning and documentation, and as such, is not a separately billable service.

Ensure that its customer services representatives who respond to questions from Network Providers are informed about the requirements and process for applicable Network Providers to become trained and certified in administering the CANS Tool and can respond to questions from Network Providers about these requirements and processes. The Contractor shall provide training to its newly hired and existing customer services representatives about when, where and how Network Providers obtain CANS training and certification, and shall provide refresher trainings as directed by EOHHS and as the Contractor determines is necessary.

Ensure that its customer services representatives who are assigned to respond to inquiries from Covered Individuals are informed about the use of the CANS and other CBHI Services, and can respond to Covered Individuals' questions about them. The Contractor shall provide training to its newly hired and existing customer services representatives about the CANS Tool and how it is generally used in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services, and Transitional Care Units.

As directed by EOHHS, ensure that Covered Individual materials, including but not limited to the Handbook for Covered Individuals, describe the CANS Tool and its use in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services for Covered Individuals under the age of 21.

As directed by EOHHS, ensure that appropriate Network Provider materials exist to describe the CANS Tool, the requirements and process for CANS Tool training and certification, and the CANS IT System.

Be able to access and use the CANS IT System and data contained therein to integrate with clinical data, and use in reporting as directed by EOHHS.

Participate in any testing or development processes necessary for EOHHS to develop and refine the CANS IT System.

**CBHI Service Rates**

As directed by EOHHS, the Contractor shall contract by the Service Start Date with the existing network of Providers to provide the following CBHI Services, when Medically Necessary, to Covered Individuals in the Coverage Types specified, unless otherwise directed by EOHHS. For each of these services the Contractor shall establish Network Provider rates at or above the rate floor set by DHCFP and shall use procedure codes as directed by EOHHS to provide payment for such services.

Intensive Care Coordination: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

Family Support and Training Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

Therapeutic Mentoring Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth; and

In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support) to all Covered Individuals under age 21.

As directed by EOHHS, the Contractor shall contract with ESP Providers to provide Youth Mobile Crisis Intervention Services, when Medically Necessary, to all Covered Individuals under the age of 21. For this service, the Contractor shall establish Network Provider rates at or above the rate floor set by DHCFP and shall use procedure codes as directed by EOHHS to provide payment for such services.

**CBHI Service Authorization**

The Contractor shall inform EOHHS in writing of its authorization procedures for Behavioral Health Covered Services for Covered Individuals under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Network Providers in learning how to utilize Contractor's authorization procedures for CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to services. In the event that Contractor's authorization procedures for CBHI Services result in delays or barriers to accessing Medically Necessary BH Covered Services, the Contractor shall modify such authorization procedures. The Contractor shall coordinate with other MassHealth payers to publish a single document that describes the authorization procedures for all MassHealth payers for these services.

The Contractor shall ensure that the authorization procedures established for Intensive Care Coordination (ICC) and Family Support and Training (FS and T) allow for at least the first 28 days of services to be provided without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC.

The Contractor shall ensure that its authorization procedures comply with all provisions of **Section 4.2** of the Contract and, in addition, that all authorization approvals for ICC and FS and T are provided telephonically or electronically.

**Management of CBHI Service Provision**

The Contractor shall:

Ensure that Network Providers of CBHI Services provide each such service in accordance with all EOHHS-approved CBHI Services performance specifications and CBHI Services Medical Necessity criteria.

Ensure that appropriate members of Providers' staffs participate in CBHI training, coaching, and mentoring as approved by EOHHS for CBHI training. The Contractor shall ensure that such members of Providers' staffs complete CBHI training, and utilize their new skills in service delivery. If the Provider is not participating in CBHI training, the Contractor shall engage in Provider Network management activities to increase training.

Develop operational manuals for selected CBHI services, including but not limited to Mobile Crisis Intervention.

Perform quality assurance and training activities for CBHI services as directed by EOHHS. These activities shall include providers within the networks of MassHealth Managed Care entities who provide CBHI Services.

Work collaboratively with all MassHealth payers to manage the network of all CBHI Service providers, including the Community Service Agencies (CSAs) that provide ICC and Family Support and Training, as well as the providers of In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, by:

Coordinating regional and statewide meetings for all CBHI service types that include all MassHealth payers, at a frequency agreed to annually by EOHHS. Contractor is responsible for coordination and administrative costs associated with such meetings; and

Coordinating with all MassHealth payers to provide joint technical assistance and network management to specific CBHI providers as necessary to address quality improvement and ensure full program implementation.

Manage the existing Community Service Agencies that are contracted to deliver ICC and FS and T services. Any changes to the CSA network must be approved in advance by EOHHS.

Maintain, revising as necessary and submitting to EOHHS for approval whenever revised, the Intensive Care Coordination and Family Support and Training Operations Manual (ICC Ops Manual). The Contractor shall ensure that the ICC Ops Manual conforms to the EOHHS-approved performance specifications for ICC and FS and T. The Contractor shall distribute the EOHHS-approved ICC Ops Manual to all CSAs in the Network.

Ensure that CSAs provide ICC and FS and T services according to both the EOHHS-approved performance specifications and the EOHHS-approved ICC Ops Manual. In the event that there are discrepancies between the two documents, the performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies and submit a correction for EOHHS approval.

Assign a point of contact for management for each CSA and identify such individual to EOHHS prior to the Service Start Date. Responsibilities shall include, but are not limited to, providing technical assistance to CSAs to answer questions regarding authorization of services and assisting CSAs in facilitating and ensuring that Network Providers engaged in a Covered Individual's treatment participate in ICC Individual Care Plan meetings.

Require CSAs to track and report monthly to the Contractor on ICCs and referrals to ICC services according to the template provided in the ICC Ops Manual. The reported data shall include de-identified information for all MassHealth Members using these services, regardless of which plan they are in.

Require CSAs to provide the Contractor with EOHHS-required data for a particular month in sufficient time to submit such reports to EOHHS by the 30th of the following month (or by the next business day after the 30th if the 30th falls on a weekend day).

Ensure that each CSA coordinates and maintains a local Systems of Care committee to support the CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person to oversee the local Systems of Care committees; the staff person's responsibilities shall include but are not limited to:

attending meetings of the Systems of Care committees on a quarterly basis;

monitoring System of Care committees' activities and issues on a monthly basis through review of meeting minutes; and

conducting network management meetings with the CSAs.

In collaboration with, and as further directed by EOHHS, develop a plan to ensure that the quality of ICC and FS and T services is measured using tools that are consistent with national Wraparound standards, such as the

Wraparound Fidelity Index tool and the Team Observation measure ("fidelity tools"), and provide CSAs with such fidelity tools at no cost to the CSAs. In addition, use tools such as the MA DRM (Document Review Measure) to review medical files in both ICC and IHT.

Generate a random sample of 50 youth with Serious Emotional Disturbance, who, as indicated in their CANS assessment, are currently receiving outpatient therapy services and, for the previous 12 months have not received either Intensive Care Coordination or In-Home Therapy. For each of these 50 youth, the Contractor shall review the clinical record and interview the youth's therapist and caregiver, to obtain answers to the questions EOHHS has provided to the Contractor. The Contractor shall report the results of this sample survey to EOHHS by June 14, 2013.

In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM or another tool approved by EOHHS to evaluate the adequacy of medical record keeping for both ICC and In-Home Therapy Services (IHT). The Contractor shall apply the approved quality assessing tool at least annually on a mix of ICC and IHT services provided across all of the Contractor's regions. The Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 25 Covered Individuals medical files per region per Contract Year.

**CBHI Access Reporting**

The Contractor shall ensure that the web-based Behavioral Health Service Access System or the Contractor's equivalent system, as referenced in **Section 3.4.A.12** above, is updated at least once a week for CBHI Services (ICC, IHBS, TM and IHT) to show access and availability.

CBHI Service reporting must be available to the public on the system.

CBHI access and availability reports must be reported monthly from this system.

**Special Service Initiatives**

During the term of the Contract the Contractor shall propose for EOHHS's review and approval special new services and programs for Covered Individuals for which the Contractor may need to adapt its Provider Network. The Contractor shall perform a cost-benefit analysis for any new service it proposes to develop, as directed by EOHHS, including whether the proposed services would have an impact on Base PMPM Capitation Rates or the Administrative Component of the MassHealth Capitation Payment.

The Contractor shall implement new special services and programs as approved by EOHHS.

**Network Administration**

**Network Provider Database**

The Contractor shall maintain:

An up-to-date database that contains, at a minimum, the following information on Network Providers:

Network Provider name;

contracted services;

site address(es) (street address, town, ZIP code, region of the state);

site telephone numbers;

site hours of operation;

Emergency/after-hours provisions;

professional qualifications and licensing;

areas of specialty relating to Behavioral Health conditions and MassHealth populations listed in **Sections 3.1.B.6** and **3.1.B.7** above;

cultural and linguistic capabilities;

malpractice insurance coverage and malpractice history;

credentialing status;

status as women- or minority-owned or -controlled organization; and

Provider e-mail address.

A list of Network Providers, sorted by type of service and by Network Providers' capability to communicate with Covered Individuals in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to Network Providers, PCC Plan Enrollees, EOHHS, DMH and other interested parties upon their request and at no charge.

**Network Provider Policy and Procedure Manual**

The Contractor shall:

Prior to the Service Start Date, develop and submit to EOHHS for approval a Provider policy and procedure manual, and, following EOHHS approval, publish the manual on Contractor's website and electronically distribute a hyperlink to the manual to all Network Providers. At a Network Provider's

request, also electronically distribute the manual to the Providers. The manual shall include, at a minimum, information on:

The Contract, the Contractor, and program priorities;

How to verify a Covered Individual's eligibility for MassHealth Behavioral Health Covered Services;

Network Provider Credentialing Criteria;

Provider Network management;

Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all BH Covered Services;

Clinical Criteria for admission, continued stay, and discharge for each BH Covered Service;

Administrative and billing instructions, including a list of procedure codes, units and payment rates;

How to appeal payment and service denial decisions;

Reporting requirements for Serious Reportable Events and Reportable Adverse Incidents; and

Performance specifications for each Behavioral Health Covered Service.

As necessary, modify or supplement the policy and procedure manual by distributing periodic notices to Network Providers;

Review the manual at least biannually and amend it, if necessary, in consultation with EOHHS; and

Redistribute the amended portions of the manual to Network Providers.

**Performance Specifications**

The Contractor shall:

Require all Network Providers to accept the Contractor's performance specifications that have been approved by EOHHS;

Develop and maintain performance specifications for Network Providers and develop performance specifications for new BH Covered Services; and

At least annually, review and update as necessary the performance specifications including any new performance specifications that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

**Network Provider Protocols**

The Contractor shall develop, maintain and utilize EOHHS-approved Network Provider protocols. The protocols must address the following:

How the Contractor intends to ensure, for a particular Covered Individual's needs, that a qualified and clinically appropriate Network or non-Network Provider:

is available to provide the particular BH Covered Service;

is accessible within the access standards required by the Contract, taking into account the availability of public transportation;

is accessible to individuals with physical disabilities, if appropriate (see **Sections 3.1.B.7** and **3.1.G** and **H**); and

has the ability, either directly or through a skilled medical interpreter, to communicate with the Covered Individual in his/her primary language (see **Sections 3.1.B.7** and **3.1.G** and **H**).

How the Contractor intends to facilitate communication between Network Providers and the Contractor, and between Network Providers and PCCs, in a manner that engages the Providers and overcomes barriers to communication.

The Contractor shall require Network Providers to submit to the Contractor a written report of all Reportable Adverse Incidents, using the form found in **Appendix F** or other similar form acceptable to EOHHS, according to the following guidelines:

Network Providers of 24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

Network Providers of non-24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents that involve the death of a Covered Individual.

The Contractor shall require Network Providers to coordinate MassHealth Covered Services with the Covered Individual's care manager where the Covered Individuals are receiving Care Management services through the Contractor and/or the case manager when the Covered Individual is receiving case management through a state agency (e.g., DMH, DCF, DDS, DYS).

The Contractor shall require Network Providers to comply with DPH's regulations barring payment for services related to a Serious Reportable Event.

The Contractor shall require Network Providers to comply with all of the following Massachusetts regulations and DMH policy memorandums:

DMH Policy Memorandum #96-3R of August 22, 1996, on informed consent, found at http://www.mass.gov/eohhs/docs/dmh/policy/policy-96-3r.pdf, or any successive policy or regulation;

DMH regulations on human rights and restraint & seclusion at 104 CMR 27 and 104 CMR 28, or any successive regulation; and

M.G.L. c. 123, § 23.

The Contractor shall require its Network Providers of Community-Based Acute Treatment Services and Transitional Care Units to comply with Department of Early Education and Care (DEEC) standards for the licensure or approval of residential programs serving Members under 18, as set forth in 102 CMR 3.00, et seq. For those CBAT and TCU Providers that are not located in a site licensed by DEEC, the Contractor shall ensure that these programs are located in a facility that is licensed by DMH and/or DPH.

The Contractor shall require its Network Providers to inform Covered Individuals of their rights under DMH regulations concerning human rights**.**

The Contractor shall comply with EOHHS protocols to ensure access to Behavioral Health Covered Services and tracking in the EOHHS Data Warehouse and MMIS systems by adhering to the following requirements:

Maintain a unique Network Provider identification number for each Network Provider, as described in **Section 9.3.A**.

Submit to EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department by the Service Start Date a list of all Network Providers who are both MassHealth Providers and Network Providers (dual Providers). The Contractor shall inform EOHHS's Enrollment Broker upon enrolling or disenrolling any dual Provider from its Provider Network.

Inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department immediately upon enrolling any Provider who is not also a MassHealth Provider in its Provider Network. Such notification shall include the following data elements:

Network Provider name, address and telephone number;

Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

Network Provider or legal entity's tax identification number; and

Effective date of the Network Provider's enrollment in the Provider Network.

The Contractor shall submit to the Customer Services vendor all updates to the list or its data elements whenever they occur.

**Network Provider Administrative Education and Training**

The Contractor shall develop an education and training plan that provides appropriate information and learning sessions for Network Providers and their staff. Such education and training plan shall be submitted to EOHHS for approval and shall include, at a minimum:

A schedule for the development and release of educational materials;

A schedule for the development and timing of training sessions;

Regional training opportunities for Network Providers' clinical and administrative staff; and

Proposed education and training topics, including but not limited to:

new changes to policies and procedure prior to their implementation;

basics of MassHealth coverage and payment requirements; and

quality improvement efforts and the Network Provider's role, include linkages across Behavioral Health and physical health services.

**Claims Handling**

The Contractor shall:

Unless otherwise approved by MassHealth, operate from the Contractor's principal Massachusetts place of business a Claims review, processing and payment system for Network Providers that furnish BH Covered Services;

Pay all Clean Claims for all Behavioral Health Covered Services authorized by the Contractor and furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only, within one month of receipt from Network Providers, unless the Contractor and Network Providers agree to an alternate payment schedule;

Prior to the Service Start Date, develop a procedure for denying Claims that includes a coding system for Claim denials and Claims that are pending, and incorporates the following policies:

Denial of reimbursement for Claims for any services that were not authorized by the Contractor, where service authorization is required;

Denial of reimbursement for Claims that are not submitted in compliance with the Contractor's administrative and billing submission requirements;

Denial of Claims for BH Covered Services provided to individuals who are neither Covered Individuals nor Uninsured Individuals or persons covered by Medicare only who have received ESP Services;

Denial of Claims for Covered Individuals when such services are paid for by Medicare or other health insurance; and

Where a Claim review results in a denial, preparation and mailing of the Claim denial to the Network Provider within two months of receipt of the Claim;

Develop an Internal Appeal process for reviewing and resolving denied Claims and payment disputes, and implement it as of the Service Start Date. The Internal Appeal process shall include the following:

Written policies and procedures for the filing, receipt, prompt resolution and documentation of all Internal Appeals brought by a Network Provider;

A means for assessing and categorizing the denied Claims and payment disputes;

Time frames for resolution and response by the Contractor; and

A definitive statement that Network Providers do not have a right to review or appeal a denied Claim directly to EOHHS.

**Retrospective Utilization and Review of Network Providers**

The Contractor shall:

Develop a description of its approach to retrospective utilization review of Network Providers and submit it to EOHHS for approval no later than six months after the Service Start Date. Such approach shall include a system to identify utilization patterns of all Network Providers by significant data elements and established outlier criteria for both Inpatient and Outpatient Services.

Conduct retrospective and peer reviews of a sample of Network Providers to ensure that the services furnished by Network Providers were provided to Covered Individuals, were appropriate and Medically Necessary, and were authorized and billed in accordance with the Contractor's requirements.

**Program Integrity, Fraud and Abuse Prevention, Detection and Reporting**

Program Integrity Requirements – Internal Controls

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

Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards;

The designation of a compliance officer and a compliance committee that is accountable to senior management;

Effective training and education for the compliance officer and the Contractor's employees;

Effective lines of communication between the compliance officer and the Contractor's employees;

Enforcement of standards through well-publicized disciplinary guidelines;

Provision for internal monitoring and auditing; and

Provision for prompt response to detected offenses, and for development of corrective action initiatives.

Provider and Covered Individual Fraud and Abuse Prevention, Detection and Reporting

The Contractor shall:

Develop and maintain a comprehensive internal fraud and abuse program to detect and prevent fraud and abuse by Network Providers and Covered Individuals;

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

Upon a complaint of fraud or abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether, in the Contractor's judgment, there is sufficient reason to believe that the Provider or the Covered Individual has engaged in fraud or abuse, and where sufficient reason exists, report the matter in writing to EOHHS within 10 days;

If the Contractor's preliminary review or any further review or audit of a Network Provider suspected of fraud involves contacting the Network Provider in question, first notify EOHHS and receive its approval prior to initiating such contact;

Make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by the organization or its subcontractors;

Require Network Providers to implement corrective actions or terminate Provider Agreements, as appropriate;

Submit ad hoc and semiannual written reports on its fraud and abuse activities according to the format specified by EOHHS. Said reports shall include the items outlined in **Appendix E-1**;

Have the CEO, CFO, or compliance officer certify in writing on an annual basis to EOHHS, using the template in **Appendix E-3**, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with **Section 3.7.H** of this Contract and has not been made aware of any instances of fraud and abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;

Notify EOHHS in writing within 10 calendar days if it or, where applicable, any of its subcontractors receive or identify any information that gives them reason to suspect that a MassHealth Provider or Covered Individual has engaged in fraud as defined under 42 CFR 455.2. In the event of suspected fraud, no further contact shall be initiated with the Provider or Covered Individual on that specific matter without EOHHS's approval;

Cooperate fully and, where applicable, require its subcontractors to cooperate fully with the Office of the Attorney General's Medicaid Fraud Division (MFD) and the Office of the State Auditor's Bureau of Special Investigations (BSI). 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 Medicaid 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.

Notify EOHHS of all Provider overpayments above $75,000 or any voluntary Network Provider disclosures resulting in the receipt of overpayments in excess of $75,000, even if there is no suspicion of fraudulent activity.

Employee Education about False Claims Laws

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.

If the Contractor is subject to such federal requirements, the Contractor must:

on or before September 30 of each year, or such other date as specified by EOHHS, provide written certification, in a

form acceptable to EOHHS and signed under the pains and penalties of perjury, of compliance with such federal requirements;

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

initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

Failure to comply with this section may result in intermediate sanctions in accordance with **Section 13.18**.

Fraud and Abuse Prevention Coordinator

The Contractor shall designate a fraud and abuse prevention coordinator, who may be the Contractor's compliance officer, and who is responsible for the following:

Assessing and strengthening internal controls to ensure Claims are submitted and payments properly made;

Developing and implementing an automated reporting protocol within the Claims processing system to identify billing patterns that may suggest Network Provider and/or Covered Individual fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

Conducting regular reviews and audits of operations to guard against fraud and abuse;

Receiving all referrals from employees, Covered Individuals or Network Providers involving cases of suspected fraud and abuse and developing protocols to triage all referrals involving suspected fraud and abuse;

Educating employees, Network Providers and Covered Individuals about fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per M.G.L. c. 12, § 5J; and

Establishing mechanisms to receive, process, and effectively respond to complaints of suspected fraud and abuse from employees, Providers and Covered Individuals and report such information to EOHHS.

**Reporting**

The Contractor shall submit to EOHHS all required reports related to Network Providers and Provider Network management, as described in this **Section 3** or in **Appendix E-1**, in

accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

# CLINICAL SERVICE AND UTILIZATION MANAGEMENT

## Administrative Requirements

### Overview

The Contractor shall:

As of the Service Start Date, perform all clinical and Utilization Management (UM) functions and be responsible for the clinical management of Network Providers as described in this Contract.

Develop the Clinical Criteria to govern the authorization of services provided under the Contract. As part of the development process, the Contractor shall consult with experts who are familiar with standards and practices of mental health and substance abuse treatment for adults and children and adolescents in Massachusetts. The Contractor shall:

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

Annually review, and update as necessary, the Clinical Criteria and any other clinical protocols that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

Develop and maintain UM policies and procedures, including but not limited to policies and procedures for service authorizations that are consistent with the EOHHS-approved Clinical Criteria the Contractor has developed, and with the requirements set forth in **Section 4.2**. The Contractor shall:

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

Annually review, and update as necessary, the UM policies and procedures and submit any proposed changes to EOHHS for prior review and approval. The UM policies and procedures shall be conveyed through staff training and supervision, and shall:

ensure that Covered Individuals receive the care that is Medically Necessary; and

place emphasis on ensuring that BH Covered Services are not over-utilized or provided without a determination of Medical Necessity.

**Staffing**

The Contractor shall employ a multidisciplinary clinical staff at staffing levels that ensure an adequate ratio of staff to Covered Individuals to perform the clinical, UM and Care Management Program functions of the Contract, including authorizing and coordinating services.

The Contractor shall ensure that the Chief Medical Officer or an Associate Medical Director is available 24 hours per day, seven days a week, for decision-making and consultation with the Contractor's clinical staff and Network Providers.

The Contractor shall make best efforts to ensure that the clinical staff described herein have never had any disciplinary or other type of sanction action taken against him or her by the relevant professional licensing or oversight board, or the Medicare or Medicaid program. The Contractor shall require its clinical staff to disclose to the Contractor any such action taken against current Contractor staff, and the Contractor shall inform EOHHS within five days of becoming aware of any such action.

Staff must include:

A full-time Chief Medical Officer who is designated as key personnel. The Chief Medical Officer shall: be board-certified in psychiatry and/or internal medicine; be in compliance with all professional licensing requirement; and have at least two years of experience in managed BH care, peer review, or both.

At least two full-time equivalent (FTE) Associate Medical Directors, each of whom shall be physicians, and:

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

One shall be board-certified or board-eligible in internal medicine, with experience in integration of care across medical and Behavioral Health Providers and shall be responsible for the oversight of the Care Management Program described in **Section 6.2**.

One shall be responsible for the oversight of the Quality Management program described in **Section 8**.

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

Supervisory clinical staff with expertise in medical or Behavioral Health care who represent nursing, social work, psychology, substance abuse, counseling or other

BH fields, possess sufficient educational background and experience, have all applicable professional licenses, have experience in managed care, UM, and QM.

Supervisory staff that include subject matter experts in Severe and Persistent Mental Illness, Severe Emotional Disturbances in children and adolescents, intellectual disabilities, substance abuse treatment, and treatment of persons with Dual Diagnosis.

Staff clinicians at the master's level or bachelor's level. Bachelor's-level staff shall perform tasks not pertaining to Medical Necessity determination.

**Training and Supervision**

The Contractor shall ensure that all staff are appropriately licensed at hiring and during the tenure of employment. In addition, the Contractor shall:

Ensure that staff clinicians receive weekly group or individual clinical supervision to ensure standardization and quality.

Ensure that clinical staff obtain the training (i.e., CEUs, CMUs) needed to maintain their professional licensing.

Ensure that clinical staff are trained on Clinical Criteria, Utilization Management standards and on Member rights for Internal Appeals and Grievances.

**Service Authorization, Utilization Review, Clinical Service Coordination and Clinical Referral**

**Policies and Procedures for Service Authorization**

Standards for Clinicians

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

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

The clinician(s) coordinating and authorizing adult mental health services must have experience and training in adult mental health services.

The clinician(s) coordinating and authorizing child and adolescent mental health and substance abuse services must have experience and training in child and adolescent mental health and substance abuse services, including services for Children in the Care and/or Custody of the Commonwealth and children who have experienced trauma.

The clinician(s) coordinating and authorizing adult substance abuse services must have experience and training in adult substance abuse services.

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

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

Service Authorization Procedure

The Contractor shall implement, as of the Service Start Date, its written policies and procedures for processing of requests for initial and continuing authorizations of services which, among other things:

Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a board-certified or board-eligible psychiatrist or health care professional who has appropriate clinical expertise treating the condition or disease at issue, except as provided in subsection **2.b**;

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

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

Consult with the requesting Network Provider when appropriate;

Make authorization decisions and provide notice as follows and as further specified in **Section 7.6**.

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

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

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

For expedited service authorization decisions, where the Network Provider indicates or the Contractor determines that following the standard timeframe in subsection **2.e.1)** could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as follows:

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

the Covered Individual or the Network Provider requests an extension; or

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

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

In accordance with 42 CFR 438.6(h) and 422.208, ensure that compensation to individuals or entities that conduct Utilization Management activities for the Contractor are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Individual.

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

Specify that prior authorization shall not be required for Inpatient Substance Use Disorder Services (Level IV), Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7), and Clinical Support Services for Substance Use Disorders (Level III.5), as defined in Appendix A;

Require that Providers providing Clinical Support Services for Substance Use Disorders (Level III.5) shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee; and

If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level III.5), such activities may be performed no earlier than day 7 of the provision of such services.

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

**Clinical Referral and Service Authorization Functions**

Clinical Referrals Function

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

Service Authorization Function

In order to authorize delivery of Behavioral Health Covered Services, if appropriate, and to assist Providers and Covered Individuals in identifying Network Providers who can provide Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Service Authorization Line that is staffed 24 hours a day, seven days a week by, at a minimum, master's-level staff as described in **Section 4.1.B.4.c**. Such clinical staff shall have access to Covered Individuals' clinical and service authorization information.

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

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

The Contractor shall coordinate service authorization functions with the Care Management Program described in **Section 6.2**, as appropriate.

**Service Authorization for Specific BH Covered Services**

Inpatient Service Authorization

The Contractor shall develop Inpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

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

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

Processes to ensure placement for Covered Individuals who require Behavioral Health Inpatient Services when no inpatient beds are available;

A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

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

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

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

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

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

24-Hour Diversionary Service Authorization

The Contractor shall develop Diversionary Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

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

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

A system for authorizing and assigning an initial length of stay for all admissions to 24-hour Diversionary Services, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

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

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

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

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

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

Outpatient Service Authorization

The Contractor shall develop Outpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor

proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

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

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

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

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

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

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

**Assessment, Treatment Planning and Discharge Planning**

**Assessments**

The Contractor shall:

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

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

history of presenting problem;

chief complaints and symptoms;

past BH history;

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

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

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

current substance use;

mental status exam including assessment of suicide and violence risk;

previous medication trials, current medications and any allergies;

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

level of functioning;

the individual's strengths and, for children and adolescents, family strengths; and

name of PCC and other key Providers.

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

For Inpatient Services: within 24 hours of admission;

For Diversionary Services: within 48 hours of admission; and

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

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

Require the clinicians who provide Behavioral Health services described in **Section 3.5** to use the CANS Tool and the information gathered from its use to inform treatment planning and Discharge Planning when: providing initial Behavioral Health Clinical Assessments; as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services; and, at a minimum, every

90 days during treatment provided to Covered Individuals who are under age 21.

**Treatment Planning**

The Contractor shall ensure that its Network Providers:

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

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

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

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

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

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

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

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

Periodically review initial treatment plans and modify them as necessary;

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

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

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

In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family

members, the PCC, Network Providers of BH Outpatient Services, Family Partners, Care Coordinators, key specialists, and other identified supports.

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

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

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

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

Assign a multidisciplinary treatment team to each Covered Individual within the following time frames:

for Inpatient Services: within 24 hours of admission;

for 24-hour Diversionary Services: within 24 hours of admission.

**Discharge Planning**

The Contractor shall:

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

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

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

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

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

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

Identify barriers to aftercare and develop strategies to assist Covered Individuals with aftercare services.

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

Include in the discharge plan, at a minimum:

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

housing;

finances;

medical care;

transportation;

family, employment, and educational concerns;

natural community and social supports; and

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

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

Identified Providers, PCCs and other community resources available to deliver each recommended service;

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

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

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

In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, PCC, Network Providers of

BH Outpatient Services, key specialists, and other identified supports, but only when the consent of the individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case consent of the legal guardian is required;

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

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

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

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

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

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

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

Ensure that Network Providers of 24-hour Levels of Care furnish, with appropriate consent, a written discharge instructions to the Covered Individual, parents, guardians, residential providers, PCCs, and relevant state agencies or Contractor care managers at the time of the individual's discharge, to include, without limitation:

A list of prescribed medications and information about any potential medication side effects;

aftercare appointments;

recommended behavior management techniques when applicable; and

a Crisis Prevention Plan, including the toll-free phone number of the Member's local ESP.

Ensure that Network Providers of inpatient mental health, ICBAT and CBAT Providers furnish, with appropriate consent, a written discharge summary to the Covered Individual, parents, guardians, PCCs, Contractor care managers, and the Member's current Behavioral Health Providers within two weeks of discharge, to include a summary of:

the course of treatment;

the Member's progress;

the treatment interventions and behavior management techniques that were effective in supporting the Member's progress;

medications prescribed; and

treatment recommendations.

Ensure that the discharge plans for Covered Individuals who are DMH Clients are coordinated with the DMH Area or Site Office.

**Additional Discharge Planning Requirements for Homeless Enrollees**

The Contractor shall:

Strongly discourage Network Providers from discharging Homeless Enrollees to shelters;

Ensure that all Network Providers provide comprehensive Discharge Planning for Homeless Enrollees, and that Network Providers exhaust all potential avenues to secure placement or housing resources, with assistance from the Contractor;

Ensure that, within two business days of admission, all Network Providers complete and forward to DMH a DMH Service Authorization packet for Homeless Enrollees who appear to meet DMH clinical criteria for service eligibility;

Identify community resources for the Homeless and ensure that Network Providers are aware of and utilize all such resources to assist with Discharge Planning for Homeless Enrollees;

Collaborate with DMH to ensure that Network Providers are aware of and utilize all available DMH resources to assist with Discharge Planning for Homeless Enrollees; and

Maintain and periodically update website links to Homeless services resources on the Contractor's website to assist Network Providers with Discharge Planning for Homeless Enrollees.

**Pharmacy Support Services**

## Overview

The MassHealth Pharmacy Program is the Pharmacy Benefit Manager (PBM) for the PCC Plan Enrollees and other Covered Individuals served under this Contract.

The Contractor shall:

Support the initiatives of the MassHealth Pharmacy Program, as directed by EOHHS.

Establish and maintain the capability to receive and analyze Claims data received from the EOHHS Data Warehouse for all Covered Services, including pharmacy utilization data for all Covered Individuals.

Establish and maintain the capacity for the Contractor's pharmacy director to create and submit reports regarding Provider prescribing patterns, and Covered Individuals' pharmacy claims and utilization patterns to Providers and to EOHHS, on a case-by-case ad hoc, non-production basis (i.e., reports manually produced by the Contractor's pharmacy director.).

The Contractor's pharmacy staff shall use these reports for Care Management and reconciliation activities, including but not limited to providing current information on pharmacy utilization to ICMP and MBHP staffs and upon request to Network Providers.

The Contractor's pharmacy director shall report quarterly to MassHealth on the pharmacy-related activities the Contractor has performed in support of this Contract. This report shall include but not be limited to the following categories of activities:

1) A summary report of the frequency of the pharmacists' interactions with care managers to support Covered Individuals in the ICMP and ECC programs;
2) A summary report of the number of members in each Pharmacy Program initiatives that DUR or OCA have referred to the Contractor's care management program and the results of referral;
3) The frequency and rationale for specific queries from Covered Individuals for other projects; and
4) Educational supports to:
    a) The ICMP program;
    b) Network Providers and PCCs;
    c) Pediatric Behavioral Health Medication Initiative (PBHMI);
    d) The inpatient medication reconciliation project;
    e) The controlled substances management program; and
    f) The PharmaConnect™ project or other pharmacy clinical care alert system as directed by EOHHS.

Ensure that sufficient pharmacist and/or clinical staff with an understanding of medication(s) as it relates to the project are available to fulfill the pharmacy requirements of the Contract.

a. Prior to July 20, 2014, provide to EOHHS for approval a staffing plan that ensures the integrity of pharmacy deliverables.

b. Continually evaluate staffing needs and provide to EOHHS for approval prior to the beginning of each Contract Year a staffing plan that ensures the clinical integrity of the pharmacy deliverables.

c. The Contractor's pharmacy director, as identified to EOHHS, shall have access to pharmacy data through POPS and the POPS data query tool known as "Business Objects" to support these efforts. If the Contractor supplies a level of clinical oversight for the use of the data that is approved by MassHealth, MassHealth may consider granting additional Contractor staff access to this tool on a case-by-case basis

Coordinate pharmacy support activities, as directed by EOHHS with DMH, and EOHHS's Drug Utilization Review (DUR) and Pharmacy Online Processing System (POPS) vendors.

For the purposes of this section the Contractor shall provide Member-level information described herein only to Providers who have a record of treating the Member, or otherwise as directed by MassHealth and consistent with prevailing laws and regulations.

**Pharmacy Initiatives**

The Contractor shall support and collaborate with MassHealth on pharmacy activities and efforts, including but not limited to:

Ensuring that Network Providers have access to the most current MassHealth Drug List, and that Network Providers prescribe pharmaceuticals in accordance with the policies and instructions provided by EOHHS and reflected in the MassHealth Drug List, and other MassHealth publications.

Using Covered Individuals' drug utilization data obtained from EOHHS to inform and guide prescribing activity. As part of this effort, the Contractor shall:

Work to improve collaboration by prescribers, thereby reducing conflicting or duplicate prescribing; and

Assist Care Managers in finding and implementing ways to improve Enrollees' compliance with prescribed medication regimens.

Providing reports to PCCs, other PCC Plan Providers, and Network Providers on the patterns of prescription utilization by Covered Individuals, in an effort to increase collaboration across providers and reduce inappropriate prescribing patterns.

Whenever a Covered Individual is admitted to a BH inpatient hospital, reviewing his or her complete medication regimen to ensure optimum quality of care at the time of admission, during hospitalization, at discharge and through his or her transition to the community, as more particularly set forth in this **Section 4.4.B.4**.

The goals of this activity are to:

Encourage the use of drugs that will not require prior authorization if it is reasonably expected that the Covered Individual will continue to use the drug after discharge;

Improve consistency in prescribed medications for Covered Individuals;

Reduce disruptions in the Covered Individual's medication regimen; and

Reduce incidence of harmful drug-to-drug interactions and poly-psychopharmacy.

Medication Reconciliation Project:

1) The Contractor shall send medication history upon a Covered Individual's admission to any appropriate Contractor's BH Network inpatient hospitals and psychiatric units at general hospitals utilizing the Multiyear Work plan developed in Contract Year Three in the newly created **Appendix K.**
2) Within Contract Year Four, complete a feasibility study of the Discharge component of the Medication Reconciliation Project to include the following:
    a. Report on the Contractor feasibility of methodologies to capture discharge medications and post-discharge prescribers, reconcile with post-discharge filling record, and communicate findings to discharge prescriber. Methodology shall include documentation of PA status.
    b. Report and utilize any lessons learned including from pilot, trial, or other evidence-based methodologies to decrease the rate of medication discrepancies pre- and post-discharge among the Contractor's BH Network inpatient hospitals and psychiatric units at general hospitals.
    c. At the end of quarter three (Q3) of Contract Year Four, provide to EOHHS at the MBHP/MassHealth Pharmacy Workgroup a progress report with recommendations to inform medication reconciliation activities for Year Five.
3) Utilize the Multiyear Work plan developed in Contract Year Three to reach deliverables in **subsections 1) and 2)** above.

Within three months after the implementation date of the protocol described in **Section 4.4.B.4.b**, the Contractor shall develop and submit for review a longitudinal (multi-year) work plan informed by the evaluation described in subsection b.4) above, to establish Medication Reconciliation protocols for all BH Network inpatient psychiatric hospitals and psychiatric units at acute general hospitals.

Medication Reconciliation shall include at minimum the following activities:

1) When the admitting facility notifies the Contractor that a Covered Individual has been admitted to a Network inpatient psychiatric hospital or a psychiatric unit at a non-psychiatric hospital, the Contractor shall provide the attending physician at the Network inpatient psychiatric hospitals and to the admitting physicians at psychiatric unit of a non-psychiatric hospital, all pharmaceutical claims and

utilization within 24 hours of admissions, including the prior authorization status of each.

Prior to the Covered Individual's discharge from the inpatient stay described in subsection 1) above, the Contractor shall obtain from the inpatient psychiatric hospitals details of the discharge medication regimen, and specifically identify medications newly prescribed during the hospitalization, and any that are discontinued. The Contractor shall identify all medications that require prior authorization on the Covered Individual's discharge plan and ensure that the hospital has included the prior authorization status of each medication.

Following the Covered Individual's discharge from inpatient care, the Contractor shall provide the Primary Care Provider and/or Behavioral Health Provider with ongoing Medication Reconciliation information to ensure that the patient follows the planned mediation regimen. This shall include but is not limited to analyzing post-discharge pharmacy claims to identify adherence to prescriptions regimens, including identification of delays in refilling prescriptions. The Contractor shall use this information to coordinate care for the Covered Individual, which may include enrollment in the Care Management Program.

Managing the prescribing of psychoactive medication to Covered Individuals under age 18, including:

a. Tracking psychopharmacology use and prescribing patterns;

b. Identifying target populations (e.g. age subsets) for proposed interventions;

c. If clinically indicated, the Contractor's Child/Adolescent Psychiatrist must make prescriber/doctor outreach calls and provide MassHealth a summary of these reviews/consultations. The Contractor and MassHealth shall coordinate prescriber/doctor outreach calls to avoid unnecessary duplication of outreach to the same prescriber for the same member and purpose.

d. If clinically indicated for Covered Individuals under 6 years old who are not receiving Behavioral Health services, the Contractor shall refer such members to ICMP for care management or care coordination.

Collaborating with and assisting EOHHS in the management of the MassHealth Controlled Substance Management Program (CSMP), which was developed to identify potential misuse or abuse of controlled substances. The Contractor's responsibilities shall include the following:

a. Identify every six months a cohort of Members meeting EOHHS criteria for CSMP through the following process:
   1) Analyze the pharmacy data to determine a list of potential members that meet criteria for pharmacy lock-in.

   2) Ensure that a clinician reviews the list to eliminate those members who appear to have a medically necessary reason(s) for their controlled substance use and produce final list of members to be included in the CSMP program.

b. Supply information to MassHealth Pharmacy Program and DUR Program as directed by EOHHS to assist in the enrollment into and disenrollment of members from the program.

c. Send Members identified in **Section 4.4.B.6.a** enrollment letters as approved by EOHHS.

d. Inform methadone providers when the Covered Individuals they treat also participate in CSMP.

e. Inform ICMP of any ICMP Members in CSMP.

f. Send PCC a letter approved by EOHHS if their patient is enrolled in CSMP and not using behavioral health or ICMP services according to criteria set by EOHHS.

g. Review MMIS every other month for any CSMP member who has changed his or her PCC and notify the new PCC that the Member is enrolled in CSMP. Such notification shall be by means of an EOHHS approved provider update letter that will include most recent 6 months of controlled substance medication prescription history.

h. Identify Members for disenrollment by EOHHS based on not meeting the criteria for enrollment during the past 4 quarter, 12 month review of controlled substance utilization.

i. Sending the names, addresses, Member ID and PCCs of each member to be released from pharmacy restriction to the DUR.

j. Send out discharge letter approved by EOHHS to Member's PCC upon discharge of Member from CSMP.

k. Evaluate the CSMP for effectiveness and report results to EOHHS in a timeframe agreed to by the parties. MBHP will track enrolled and dis-enrolled CSMP Members' prescription medication utilization to monitor the effectiveness of the program and to determine cost savings according to methodology jointly established by EOHHS and MBHP, changes in controlled substance prescription patterns, changes in ED use and utilization of behavioral health services.

l. Identify and engage Enrollees in CSMP who might need Behavioral Health services and medical care and help them access such services.

m. Work with MassHealth to determine how to implement a Prescriber Lock-in Program.

Support EOHHS pharmacy initiatives by promoting and communicating the adoption of MassHealth clinical policy recommendations to PCC Plan Providers and BH Network Providers.

Implementation of a technology system of alerts:

a. Based on an evaluation by EOHHS of ValueOptions PHarmaConnect™ technology system of alerts for Contract Year 3, EOHHS will decide whether to continue using the system, to use an alternative system, or to discontinue the system, and shall notify MBHP of such decision. Upon such notification from EOHHS, MBHP will either

continue current Phase 1, work with EOHHS to use an alternative system or discontinue the system, as applicable, and

b. If EOHHS decides to continue PharmaConnect™, MBHP will propose and implement upon EOHHS approval a work plan to expand PharmaConnect™ to other MassHealth prescribers and to include additional drug classes, including non-Behavioral Health drugs.

Propose additional pharmacy interventions focused on Covered Individuals. Such interventions shall include, at a minimum:

a. Identifying and mitigating duplication of, or conflict with, other pharmacy interventions by EOHHS or its Contractors;

b. Educating PCC Plan Providers and Network Providers on pharmaceuticals used for BH conditions, through PCC Plan Management Support Services (MSS) site visits, Network Provider site visits, or other methods, including publications;

c. Educating PCC Plan Providers and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions through an alert, brochure and/or newsletter; and

d. Collaboration with DCF, DYS and EOHHS to develop a system to monitor their clients' use of pharmaceuticals for BH conditions.

Implement other pharmacy interventions as approved by EOHHS in accordance with the time frames specified by EOHHS.

**Work Group Participation**

The Contractor shall assign its staff pharmacist to participate in all appropriate pharmacy work groups as determined necessary by the EOHHS, including but not limited to:

The Drug Utilization Review (DUR) Board as well as open DUR workgroups and committees;

The DMH drug advisory committee (known as the Psychopharmacology Experts Work Group);

The Children's psychopharmacology workgroup (known as the Psychoactive Medications in Children Working Group; and

Participation in any EOHHS pharmacy strategic planning process as requested or directed by EOHHS.

**Massachusetts Child Psychiatry Access Project**

The Massachusetts Child Psychiatry Access Project consists of children's mental health consultation teams throughout the state to help PCPs meet the needs of children with psychiatric problems. The primary goals of MCPAP are to improve access to treatment for children with psychiatric problems, and to promote productive relationships between primary care and child psychiatry and rational utilization of scarce resources.

The Contractor shall:

Establish a Massachusetts Child Psychiatric Access Project (MCPAP) Unit to manage the Massachusetts Child Psychiatric Access Project, and allocate sufficient medical leadership and program administration resources to assure that the goals of the program are met and quality is maintained.

Establish and maintain a network of MCPAP Providers to provide consultation to pediatric Primary Care Practitioners (PCPs), including Primary Care Clinicians (PCCs), treating pediatric Members who may need Behavioral Health services.

Recruit pediatric PCPs across the state who have not yet signed a MCPAP participation agreement.

Ensure that MCPAP services are available statewide through multiple teams of contracted and credentialed MCPAP Providers with each team responsible for specific geographic centers across the state. Each team shall include MCPAP Providers experienced in providing pediatric mental health and substance use disorder consultation.

Maintain a system to collect Encounter data; and utilize the Encounter data collected to evaluate and analyze the effectiveness of the MCPAP.

Contract with a sufficient number of MCPAP Providers in the geographic centers across the state to ensure continuous access between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays), for PCPs to obtain pediatric psychiatry consultation, including the following:

- immediate advice to the PCP (within 30 minutes of the contact);
- referral to the MCPAP Provider team care coordinator to assist in arranging and linking to Behavioral Health services;
- referral of the child to team therapist for transitional counseling while Behavioral Health services are being arranged; or
- referral of the child to the team child psychiatrist for diagnostic or psychopharmacologic consultation.

Perform the following MCPAP responsibilities, without limitation:

- Ongoing collection of Encounter data pursuant to the Contractor’s requirements;
- Conducting ongoing outreach to recruit and enroll PCP practices and build relationships with PCPs in a MCPAP Provider’s center;
- Informing PCPs in a MCPAP Provider’s region how to access MCPAP services;
- Regular communication with PCPs regarding satisfaction with MCPAP;
- Regular communication with PCPs who underutilize MCPAP to identify barriers to using the MCPAP service;

Maintenance of up-to-date and comprehensive information for PCCs on access to Network Behavioral Health Providers;

Maintenance of a dedicated website about MCPAP that provides information about MCPAP and information about children's behavioral health topics and resources for PCPs and families for approval by EHS.

Provide quarterly aggregate progress reports to EOHHS and DMH 20 days after the closing of each quarter, which shall include the following data elements at a summary level for each month in the quarter:

Number and names of MCPAP Providers;

Number and names of PCPs enrolled in MCPAP;

A list of pediatric MassHealth PCCs, noting which PCCs have enrolled in MCPAP and which PCCs have not yet enrolled and noting efforts to enroll each unenrolled PCC;

For each MCPAP Provider and statewide: number of Encounters by type of Encounter, diagnosis, reason for contact, insurance status of the child, and name of the PCP;

For each MCPAP Provider and statewide: unduplicated count of children served, by type of Encounter, diagnosis, reason for contact, insurance status of the child, and name of PCP;

Number of Encounters of unduplicated Members, by MCPAP Provider;

Report of outcome, diagnosis, and medication per consultation;

Number of enrolled PCPs, by MCPAP Provider;

Revenue generated by billing insurers, including Mass Health and MassHealth MCOs, for direct face-to-face treatment to children and families by MCPAP Provider and statewide;

Annualized budgets for each MCPAP Provider and MCPAP Administration; and

Other program utilization data elements as identified by EOHHS, MCPAP and DMH.

EOHHS and DMH may at their discretion require additional MCPAP reporting requirements in addition to the reporting requirements set forth in **Sections 4.5.H.1-11** above.

Coordinate all MCPAP program activities with DMH, including but not limited to:

Attending monthly planning meetings and other meetings as required by DMH;

Establishing and regularly convening a MCPAP Advisory Committee to inform and advise the MCPAP Unit and DMH on program improvements and direction;

Revising program activities as requested by DMH and approved by EOHHS; and

Participating in any DMH-initiated program evaluation activities and accompanied recommendations for future direction.

Participate in national initiatives and consortiums of children's Behavioral Health consultation and collaboration programs as directed by EOHHS.

In Contract Year Four, establish and maintain a network of MCPAP for Moms Providers to provide consultation to adult primary care providers, OB/GYN providers and psychiatrists to address the needs of mothers at risk for, or experiencing, postpartum depression. In addition the Contractor shall:

1. Provide orientation and/or training in postpartum depression screening, brief intervention and referral for supportive and treatment services (when indicated) for OB/GYNs and MCPAP-enrolled pediatricians.
2. Continue enrollment of OB/GYN practices in MCPAP for Moms to address Covered Individuals' postpartum behavioral health needs.

As directed by EOHHS, participate in a DMH work group to develop financial and programmatic strategies to ensure sustainability of MCPAP within the context of alternative payment and service delivery methodologies associated with healthcare.

By the end of Contract Year Four, submit to EOHHS and DMH for review and approval a report to increase the utilization of MCPAP services at the practice and provider level. The report shall include:

1. An analysis of the current utilization and trends in the utilization of the MCPAP services at the practice and provider level;
2. An analysis of the results of the most recent annual PCP Satisfaction survey;
3. A description of the methodology used to quantify practice and provider utilization of MCPAP; and
4. Strategies to increase the effective utilization of MCPAP services.

In Contract Year Four, implement strategies to increase pediatricians' capacity to identify, provide brief intervention, and refer for treatment adolescents with substance use needs. The Contractor shall:

1. Contract with an Adolescent Substance Use Screening and Treatment Specialist for this initiative who will train all MCPAP Hubs staff in the new S2BI algorithm (a new validated screening tool for adolescent substance use developed by Dr. Sharon Levy of Boston Children's Hospital) and use of the revised SBIRT Toolkit. The MCPAP Hub staff shall maintain logs of the practices and providers they train;
2. Oversee MCPAP Hubs staff in training pediatric practices enrolled with their respective MCPAP Hubs in the new S2BI using the revised SBIRT Toolkit;

3. The MCPAP Hubs will provide contact information between enrolled pediatric practices and other SBIRT training and information resources in the state; and

4. Submit to EOHHS and DMH quarterly and annual reports, stratified by months and year to date, on aggregate de-identified adolescent substance use encounters by MCPAP Providers statewide, provided that such report will not include identifiable data except to the extent permitted by law and requested by EOHHS. The design of the report shall be submitted within 30 days of the beginning of Contract Year Four and be consistent with the requirements and be approved by DMH and EOHHS.

By the end of Contract Year Four, develop and implement for EOHHS and DMH's review and approval, strategies to increase pediatricians' capacity to identify and treat the Behavioral Health needs of children ages five and under and their families. To develop such strategies the Contractor shall:

1. Submit quarterly and annual reports (stratified by months and year to date) to EOHHS and DMH on early childhood Behavioral Health Encounters by MCPAP Providers statewide. The design of the report shall be submitted within 30 days of the beginning of Contract Year Four and be consistent with the requirements and approval of DMH and EOHHS.

2. By the end of Year Four, complete the statewide training plan described in **Section 4.5.N**. to implement the Positive Parenting Program (Triple P) within MCPAP teams, pediatric practices and community-based Behavioral Health agencies.

3. By the end of Year Four, Quarter 2, complete the Triple P technical assistance described in **Section 4.5.N**. with all accredited Triple P providers, utilizing Triple P trainers for 50% of monthly sessions.

4. Organize Peer Support groups for actively practicing accredited Triple P providers to promote sustainability of the clinical model post-grant funding.

5. For the first two quarters of Contract Year 4, submit quarterly and semi-annual report (stratified by months and year to date) to DMH on participation of parents in a Triple P Positive Parenting Program. The design of the reports will be submitted within 30 days of the beginning of Contract Year Four and be in accordance with the requirements specified by DMH.

Evaluate the implementation of the Triple P intervention. The Contractor shall:

1. Design an evaluation instrument to be approved by EOHHS and DMH to evaluate the implementation of the Triple P Positive Parenting Program training. The instrument shall include:

   a. Key indicators;

   b. Measures of success; and

c. Data collection plan.

2. By the end of Quarter 3 of Contract Year Four, complete the evaluation of the implementation Triple P intervention.

3. By the end of Contract Year Four, submit final report to EOHHS and DMH following the specifications of the evaluation instrument.

**Forensic Evaluations**

Forensic Evaluations are a clinical assessment of mental status that enables local police departments to obtain psychiatric hospitalizations, when appropriate, for persons who are arrested but not yet arraigned because the court is closed.

The Contractor shall provide a system to access Designated Forensic Professionals (DFPs) for Forensic Evaluations conducted as part of a Pre-Arraignment Protocol (PAP) as described in M.G.L. c. 123, § 18(a) (see **Appendix A-6)**. After the Contractor has conducted an initial clinical evaluation of an individual who has been arrested but not yet arraigned, the Contractor shall determine the need for further evaluation for hospitalization and issue a referral for a Forensic Evaluation. Upon receiving a referral for a Forensic Evaluation, the DFP shall:

Evaluate the arrested individual, generally at the hospital Emergency department or in a police lock-up, through an interview and other available clinical data;

Determine whether the individual is in need of hospitalization and that no other alternatives are feasible; and

Present this finding to an on-call judge who is empowered to issue a temporary commitment to a DMH facility or to Bridgewater State Hospital.

**Money Follows the Person Demonstration**

The Money Follows the Person (MFP) Demonstration is designed to assist individuals participating in the Demonstration to transition from long term care facility settings to community-based settings. Individuals participating in the MFP Demonstration that enroll in an MFP HCBS Waiver are MFP Waiver Participants. MFP Waiver Participants who are not otherwise eligible for managed Behavioral Health benefits through either the Contractor or an MCO are Covered Individuals for the purpose of this **Section 4.7**.

The Contractor shall:

1. At the request of an MFP Waiver Case Manager, provide referral assistance to in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the MFP Waiver Participant's clinically indicated Behavioral Health needs;

2. Work with the MFP Waiver Case Manager to determine care needs, and in collaboration, develop a course of treatment (i.e. individual service plan), and provide a set of services (recommend and assist with arranging and provide authorization when appropriate), based upon the individual clinical needs of the MFP Waiver Participant including, if clinically indicated, Clinical Service Coordination as described in Section 6.3;

3. When clinically indicated, refer the MFP Waiver Participant to an in-network Community Support Program to conduct a Behavioral Health Assessment;

4. Provide information regarding the MFP Waiver Program, including coverage information to contracted providers;

5. Instruct contracted providers, where applicable, to include the MFP Waiver Case Manager on the team if a multidisciplinary care team is convened;

6. Monitor the MFP Waiver Participant's Individual service plan and continue collaboration and on-going communications with the MFP Waiver Case Manager;

7. Communicate the individual service plan to and coordinate such plan with the appropriate agencies, organizations and providers; and

8. Provide an update of the MFP Tracking Report on a monthly basis.

9. Submit an application to EOHHS for enrollment as a provider of MFP Demonstration Transitional Assistance Services.

At the request of EOHHS, the Contractor shall train MFP Waiver Case Managers, and any other individuals that MassHealth identifies, contracts with or appoints to aid in transitioning MFP Waiver Participants from nursing facilities or hospitals. Such training shall include, at minimum:

a description of the purpose and goals of the Behavioral Health program and available services and support;

identification of the Network Providers available through the Contract;

a description of how to make appropriate referrals;

a process for making such referrals; and

contact information for dedicated Contractor staff that MFP Waiver Case Managers can contact to appropriately and efficiently refer an MFP Waiver Participant.

Once MassHealth determines that Covered Individual is eligible for the MFP Waiver program, the Contractor shall, within 60 days of a planned discharge:

1. Accept referrals from the MFP Waiver Case Manager; work with the MFP Waiver Case Manager to determine care needs, and identify potential behavioral health services needed, and determine what services are available in the expected community location;

2. As requested by the MFP Waiver Case Manager, provide a list of in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the need for pre-transition referrals to in-network Community Support Program to conduct a Behavioral Health Clinical Assessment and/or referral to in-network behavioral health providers for pre-transition services. Pre-transition referrals shall be made no more than 60 days prior to the planned discharge date.

3. Payment for all in-network behavioral health services provided pre-transition shall be made in accordance with Section 10.17.

**Social Innovation Financing for the Chronically Homeless Program (SIF Program)**

The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this section.

**A.** The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with SIF Program providers identified by EOHHS to provide Community Support Program (CSP) services as set forth in **Appendix A-1** and below; provided, however, that such Network Providers must meet all applicable Contract, statutory, and regulatory requirements. The Contractor shall pay its contracted SIF Program providers a case rate consistent with the current market rate for the services in **Section 4.8.C** below for each day a Covered Individual is a SIF Program participant.

**B.** SIF Program participants shall be those Covered Individuals whom the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Covered Individuals, including veterans, who are SIF Program participants. Such referrals shall only be for Covered Individuals who either:

1. Meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, i.e., is an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

2. Are identified by SIF Program providers and approved by the SIF Intermediary as an individual who is homeless and a high-cost user of emergency services.

The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Covered Individuals to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants.

**C.** Subject to Medical Necessity requirements, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide to Covered Individuals who are SIF Program participants Community Support Program (CSP) services as set forth in **Appendix A-1** in a manner consistent with the goals of the SIF Program. Such CSP services shall consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include:

1. Assisting SIF Program participants in enhancing daily living skills;
2. Providing service coordination and linkages;
3. Assisting SIF Program participants with obtaining benefits, housing and healthcare;
4. Developing a crisis plan;
5. Providing prevention and intervention; and
6. Fostering empowerment and recovery, including linkages to peer support and self-help groups.

**D.** The Contractor shall work with EOHHS to take all steps and perform all activities necessary to implement the above requirements consistent with SIF Program goals, policies and procedures as communicated by EOHHS, including but not limited to participating in meetings with the SIF Intermediary."

**Mobile Crisis Intervention/Runaway Assistance Program (MIC/RAP)**

A. The Contractor (MBHP) shall ensure that its contracted Emergency Services Program Providers (ESPs) establish a "Mobile Crisis Intervention/Runaway Assistance Program" (MCI/RAP). Through this program, as further described in this **Section 4.9**, the ESPs shall provide a temporary and safe place for Youth as defined in **Section 4.9.B** below to stay on a voluntary basis, until such Youth is transferred to an Alternative Lock-up Program or other appropriate level of service in accordance with **Section 4.9.C.4**, below.

B. For the purposes of this **Section 4.9**, the following definitions shall apply:

1.Youth –

a. Any "Child Requiring Assistance" under Chapter 240 of the Acts of 2012, currently defined as a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful

and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the child's school; (iv) is habitually truant; or (v) is a sexually exploited child; or

b. Any minor between the ages of 7 and 18 who has been arrested by police for a non-violent offense.

2. MCI/RAP site – the site the ESP maintains to operate the MCI/RAP in accordance with **Section 4.9.C.2** below. Such site may be the same site as the ESP location.

3. Non-Court Hours – Hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends, and holidays.

C. Implementation of MCI/RAP

In implementing the MCI/RAP, the Contractor shall require its contracted ESPs to:

1. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

2. Maintain a MCI/RAP site where police can bring Youth during Non-Court Hours.

3. Greet police officers and Youth who come to the MCI/RAP site during Non-Court Hours.

4. Supervise Youth brought by a police officer to the MCI/RAP site on at least a one-to-one basis until the Youth:

   a. Is transferred to a hospital level of care;

   b. Is transferred to the care of Alternative Lock-up Program (ALP) staff; or

   c. Voluntarily leaves the site.

5. If a Youth who was brought to the MCI/RAP site chooses to voluntarily leave the site,

   a. Immediately notify the police department of the city or town where the MCI/RAP site is located and the Department of Children and Families (DCF) (if the Youth is known to be in DCF custody), of the youth's departure,

b. Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123, §12, and, if determined appropriate , apply for hospitalization of such Youth; and

c. Submit a critical incident report form to the Contractor. The Contractor shall submit such report to EOHHS.

6. Designate a manager to oversee the MCI/RAP. The manager shall:

   a. Ensure MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court Hours and be available to MCI/RAP staff for consultation;

   b. Provide back-up coverage for on-call MCI/RAP staff;

   c. Train program staff regarding MCI/RAP procedures;

   d. Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

   e. On the following business day, follow up with the police department that transported the Youth to the MCI//RAP site, and follow-up with any ALP to which the Youth was transferred.

D. Implementation Timeline

1. On November 5, 2014, the Contractor shall ensure that at least two of its contracted ESPs to operate the MCI/RAP in accordance with this **Section 4.9**.
2. From January 1, 2015 through March 31, 2015, the Contractor shall:

   a. Allow, but not require, additional contracted ESPs to operate the MCI/RAP.

   b. With support from EOHHS, arrange at least one statewide meeting with all contracted ESPs to discuss full implementation of the MCI/RAP.

3. On April 1, 2015, the Contractor shall ensure that all of its contracted ESPs operate the MCI/RAP in accordance with this **Section 4.9.**

E. MCI/RAP Outreach and Training

As directed by EOHHS, the Contractor shall provide additional outreach and training to contracted ESPs and other stakeholders, including:

1. Meeting with the ESPs, police and probation officers, and ALPs to discuss the MCI/RAP;
2. In conjunction with EOHHS and its designees (such as Mass211), hosting statewide trainings or conferences, in addition to requirements outlined in Section 9 of this Contract; and

3. Training Contractor staff on MCI/RAP.

F. MCI/RAP Outcome and Output Measures

The Contractor shall require its contracted ESPs to provide quarterly and annual reports to the Contractor, who will report to EOHHS, in a form and format agreed upon by the Contractor and EOHHS, on outcomes and outputs related to the MCI/RAP, including but not limited to:

1. The number of Youth who receive a crisis intervention assessment;
2. Demographics related to Youth served including but not limited to age, gender, ethnicity and city/town of residence
3. The number of Youth unable to be maintained safely at the MCI/RAP site and require further assessment in the secure environment of the emergency department;
4. The number of Youth transferred to the care of Alternative Lock-up Program (ALP) staff; and
5. The number of Youth who voluntarily leave the MCI/RAP site.

G. Contractor Payment to ESPs for MCI/RAP

1. Each state fiscal year, the Contractor shall pay each contracted ESP $35,476.00 for its operation of the MCI/RAP.
2. The Contractor shall make the payments in **Section 4.9.G.1**, and shall account for any other costs associated with operation of the MCI/RAP, using only the payments EOHHS provides the Contractor in accordance with **Section 10.12** and the Contractor's own funds. The Contractor shall not use any other payments EOHHS provides the Contractor in accordance with **Section 10** to operate the MCI/RAP. Unless specifically directed to do so by EOHHS, the Contractor shall not include the Contractor's costs and expenditures related to the MCI/RAP in its Encounter Data submitted to EOHHS and such costs and expenditures shall not be considered when calculating any payment pursuant to the risk sharing arrangement in **Section 10.6** and **Appendix H-1**.**"**

**Reporting**

The Contractor shall submit to EOHHS all required reports related to clinical service and utilization management under the Contract, as described in this **Section 4** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

# PCC PLAN MANAGEMENT SUPPORT SERVICES

## Overview

The Contractor shall assist EOHHS in the management of the PCC Plan by providing certain administrative functions, as described in this section, on behalf of EOHHS.

### PCC Plan Management Support Services Staffing and Staff Training

The Contractor shall:

Employ appropriately qualified staff experienced in supporting providers in the areas of transformation, integration and general primary care support functions in sufficient numbers to satisfy all responsibilities. Staff shall include the following positions, unless otherwise approved by EOHHS.

1. **PCC Plan Provider Partner Support Services Director –** dedicated solely to the Contract; responsible for all applicable Provider Partner Support Services activities as described in **Section 5.**
2. **PCC Plan Provider Partner Support Specialists-**dedicated solely to the Contract , with appropriate provider management, QM, provider relations, and relevant background and experience; responsible for conducting activities on behalf of EOHHS as described in **Section 5.3**, including an onsite presence at EOHHS, if requested to assist with any duties performed by EOHHS related to PCC support and education.

Ensure that all MBHP staff providing services under this Contract are informed about relevant aspects of MassHealth policy changes, including but not limited to EOHHS payment reform and integration initiatives, or other skills associated with this Contract. Within two months of the first day of each Contract Year, in consultation with EOHHS, determine the need for training some or all Contractor staff in relevant aspects of MassHealth policy updates, payment reform and integration initiatives, or other skills associated with this Contract and, if necessary, develop and provide such training within a timeline agreed upon with EOHHS.

Annually, within the first three months of the first day of the Contract Year, develop a plan for training and enhancing staff performance on all functions associated with the PCC Plan Management Support Services. Training material must receive prior review and approval from EOHHS.

### PCC Plan Management Support Services (MSS) Program

### PCC Plan Management Support Services (MSS)

The Contractor shall:

Establish, implement and maintain a PCC Plan Management Support Services (MSS) program for PCCs that measures, monitors and promotes

improvements in health care delivery systems, including integration of care, at the PCC practice level;

Review, update, and establish any new written standard operating policies and procedures for the Contractor's staff associated with the PCC Plan (PPSS) program;

Provide to EOHHS copies of the standard operating policies and procedures for the PCC Plan PPSS program within six months of the first day of the Contract Year and modify such policies and procedures in support of the PCC Plan as directed by EOHHS;

Accept and utilize any data files that EOHHS provides in connection with the MSS program, in the format determined by EOHHS;

Notify EOHHS if, after diligent effort on the part of the Contractor, a PCC refuses to cooperate with the MSS profiling process or other Contract requirements;

Develop and implement written action plans, as needed, related to reports produced for PCC Services locations. Prior to disseminating such reports, the Contractor shall certify the accuracy of the data to EOHHS regarding these reports as required in Section 11.1.B; and

Provide support to PCCs consistent with integration of Behavioral Health and medical care services.

**PCC Performance Dashboard**

PCC Performance Dashboard (PD)

The Contractor shall:

a. Utilizing data files provided by EOHHS, create a web-based PCC-specific PCC Performance Dashboard (PD) for all PCCs and/or PCC Service Locations with PCC Plan panels that meet the threshold number of Enrollees as agreed to by EOHHS and the Contractor, and other PCCs, as requested by EOHHS; the PD shall be implemented and updated according to a schedule determined by EOHHS;

b. Produce the PDs as requested by EOHHS;

c. Ensure the PDs are formatted in a user-friendly style approved by EOHHS;

d. One month prior to the dissemination of the PD, prepare for EOHHS's prior approval a written user's guide that explains the purpose of the report and the information it contains;

e. Include in each PD PCC-specific site information and PCC panel Enrollee demographics;

f. Include in each PD all measures provided by EOHHS. Measures shall be reported by both PCC and PCC Service Location level, when applicable. Such measures are subject to change during the term of the Contract. For each measure the Contractor shall:

**1)** Present PCC-specific data; and

**2)** Compare each PCC's performance using appropriate benchmarks and trended indicator rates as directed by EOHHS, such as:

**a)** aggregate PCC Plan performance;

**b)** available national, state, local or industry benchmarks; and

**c)** the PCC's PD trended data.

g. Include in the PD a one-page summary of trended rates for the PCC and by PCC Service Location for all clinical measures, as appropriate; compare the Service Location rates to that of the PCC entity, other PCC Service Locations, the overall PCC Plan rates, and other benchmarks as directed by EOHHS.

h. Deliver PDs to PCCs and PCC Service Locations through a password-protected, web-based portal prior to the Performance Dashboard site visits required by **Section 5.2.C.2**.

i. Within one business day of posting the updated PD (in accordance with **Section 5.2.B.2.a**), notify PCCs and PCC Service Location via email that the reports are available.

j. Design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration, including but not limited to:

**1)** Acute inpatient admission over time by Enrollees;

**2)** Psychiatric inpatient admission over time by Enrollees;

**3)** Pharmacy utilization; and

**4)** Other measures.

k. Maintain a secure website that provides PCCs and PCC Service Locations access to all current PD reports and ensure that the current PD reports remain posted until the next cycle's PD is released. The Contractor shall ensure that PCC-specific PDs are not available to others by establishing and maintaining a secured system of log-in identification and passwords which may be set by the PCC or PCC Service Location for accessing its PCC-specific PD.

EOHHS and the Contractor may negotiate alternate PD measures, report formats, methods and timeframe for the production and distribution of the PD. The Contractor shall create and distribute the PD in accordance with any alternate measures as approved by EOHHS.

Additional Reports

The Contractor shall propose to EOHHS additional reports to support the PCC MSS, as appropriate.

The Contractor shall produce additional PCC MSS reports, including but not limited to analysis of trends identified from PCC MSS data, and other supplemental and management reports as negotiated by the parties.

EOHHS may at its discretion instruct the Contractor to replace the production of certain existing reports with reports generated for PCCs and PCC Service Locations as part of other EOHHS programs and/or initiatives (e.g., PCPR).

**PCC MSS Site Visits**

PCC MSS Introduction Visit

The Contractor shall:

Within three months after a new provider has become a PCC, conduct a PCC MSS introduction visit, regardless of the PCC's enrollment roster/panel size.

Ensure that the MSS introduction visit includes:

An introduction to the Contractor and a description of the Contractor's role and the PCC Plan MSS;

The current EOHHS and PCC Plan goals and policies;

A description of available Contractor programs, including but not limited to, the PCC Plan ICMP, ESP, NAL, etc.

A description of all appropriate materials that are used in the PCC Plan MSS.

The PCC's Regional Network Manager's name, telephone number, and e-mail address;

The PCC Hotline number and a list of reasons a PCC might want to call the PCC Hotline; and

Time frames for the PCC's or PCC Service Location's expected initial MSS site visit; and

A description of any additional reports and/or information as directed by EOHHS.

PCC MSS Site Visits

After the introduction visit, the Contractor shall conduct PCC MSS site visits according to an EOHHS-approved schedule. The Contractor shall review the needs of the PCC or PCC Service Location prior to scheduling a site visit, including PCC-specific and/or PCC SL-specific data, and shall conduct site visits to PCCs and PCC Service Locations as appropriate, or as requested by the PCC or PCC Service Location.

The Contractor shall develop and propose for EOHHS's approval a detailed plan for MSS site visits to all PCCs and PCC Service Locations that meet the site visit criteria agreed to by EOHHS. Such proposal shall include, at a minimum, the following elements:

1) A schedule for MSS site visits that is specific to each PCC and PCC Service Location, based on the agreed-upon site visit criteria and the PCC's performance, as set forth in the PCC-specific reports;
2) The criteria by which PCCs and PCC Service Locations will be evaluated for modification of their current MSS site visit schedule;
3) Timeframes for when PCCs and PCC Service Locations will be evaluated for modification of their current site visit schedule;
4) The content and subject matter of the site visits or, for those PCCs that may not receive a visit, other communications;
5) A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;
6) A description of how the Contractor will prioritize integration of Behavioral Health and medical care, and Care Management efforts for Enrollees as part of each site visit;
7) A method for documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations;
8) A method and timeframe for evaluating the success of and improving MSS site visits under the Contractor's proposal; and
9) A description of any additional reports and/or information as directed by EOHHS.

Subject to EOHHS approval, the Contractor shall implement its MSS site visit proposal.

The Contractor shall work with PCCs and PCC Service Locations to schedule a convenient time for MSS site visits.

The Contractor shall make best efforts to involve the medical director of the PCC in the site visit, and shall advise the PCCs and PCC Service Locations that appropriate clinical and non-clinical staff should attend the site visit.

The Regional Network Manager shall discuss other related PCC issues as identified by the PCC or the Regional Network Manager, or as directed by EOHHS.

The Regional Network Manager shall conduct the MSS site visit and other EOHHS or Contractor staff shall attend, at the discretion of EOHHS.

At each PCC MSS site visit, the Regional Network Manager shall review with the PCC any new PCC MSS Support Materials along with the catalog, which includes instructions for ordering new and existing material, as described in **Section 5.2.D.1**, below.

The Contractor shall inform PCCs and PCC Service Locations that they may call the PCC Hotline to order additional copies of PCC MSS Support Materials (see **Section 5.2.D**), and shall furnish such materials upon request.

The Contractor shall maintain and document ongoing communication with PCCs and PCC Service Locations through additional site visits, email, and telephone follow-up, as appropriate or as directed by EOHHS.

The Contractor and EOHHS may negotiate a modified schedule and methodology for PCC MSS site visits and, with EOHHS approval, the Contractor shall perform MSS site visits in accordance with such alternate schedule and methodology.

The Contractor shall prepare, deliver to, and discuss with PCC Plan staff a detailed report of site visits on a monthly basis. The Contractor and EOHHS may negotiate report format and contents during the term of the Contract."

PCC MSS and BH Joint Visits

The Contractor shall develop and propose for EOHHS's approval a detailed plan for PCC MSS and BH joint site visits. Such proposal shall include, at a minimum, the following elements:

The criteria by which joint visits will be conducted;

The content and subject matter of the site visit;

A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;

A description of how the Contractor will support integration of Behavioral Health and medical care, and Care Management efforts for Enrollees as part of each site visit;

A method of documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations, such as the PCC MSS database; and

A method and timeframe for evaluating the success of and improving joint site visits under the Contractor's proposal. The evaluation of success shall be based on information in the PCC MSS database.

**PCC Compliance with PCC Provider Contract with EOHHS**

The Contractor shall:

Develop and propose to EOHHS for review and approval a process for annually reviewing the compliance of selected PCCs with certain identified requirements in their PCC Provider Contracts (**Appendix C-2**), as well as other requirements specified by EOHHS;

Annually submit a report to EOHHS documenting the process used to monitor compliance of those PCCs identified in subsection **1** with the PCC Provider Contract and the Contractor's findings regarding PCC compliance;

Assist PCC Plan staff with ensuring that all providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and

Perform all follow-up activities in connection with subsection **3**, as directed by EOHHS.

**PCC Capacity**

The Contractor shall report to EOHHS at least quarterly or as otherwise directed by EOHHS, in a format agreed to by EOHHS, the following:

A geographic access report for adult PCCs and PCC Service Locations and pediatric PCCs and PCC Service Locations demonstrating access by geography; and

A PCC-to-Enrollee ratio report showing open and closed adult PCCs and PCC Service Locations and pediatric PCCs and PCC Service Locations per number of Enrollees.

The Contractor shall monitor Enrollees' voluntary changes in PCCs and PCC Service Locations to identify Enrollees with multiple and frequent changes in PCCs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long-term patient-doctor relationship with one's PCC.

The Contractor shall contact Enrollees who make frequent PCC changes to determine whether the Enrollee could benefit from a range of interventions, including Care Management.

## PCC Plan Network Access and Availability

The Contractor shall ensure that all Enrollees have access to Medically Necessary MassHealth Covered Services that are the subject of this Contract. Access in this context refers to the ability of the Enrollee to obtain services at the time such services are needed. Such service refers to both telephone access and ease of scheduling an appointment. Availability means the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership. During the first year of the Contract, the Contractor shall collaborate with EOHHS to establish access and availability standards.

General

The Contractor shall monitor the PCC Plan's capacity to serve Enrollees in accordance with the access standards specified below in subsection **2** on a quarterly basis, or sooner where there is a significant change to either the PCC Plan or the PCC Plan Network that would affect the adequacy and capacity of services. Significant changes shall include, but are not limited to:

Changes in MassHealth Covered Services;

Enrollment of a new population in the PCC Plan; and

Changes in provider payment methodology.

Access and Time Standards

The Contractor shall monitor the PCC Plan Network to ensure that Enrollees have access to Covered Services 24 hours/seven days per week. Enrollees must be provided a telephone number to contact the PCC during the hours when the office is not open and the PCC shall respond to all such Enrollee calls within one hour.

In addition, the Contractor shall ensure that Enrollees receive Covered Services within the time periods provided below.

For physical health services:

Emergency Services: Immediately upon Enrollee presentation at the service delivery site.

Primary Care:

Within 48 hours of the Enrollee's request for Urgent Care Services;

Within 10 calendar days of the Enrollee's request for non-urgent symptomatic care; and

Within 45 calendar days of the Enrollee's request for non-symptomatic care, unless an appointment is required more quickly to assure the

provision of screenings in accordance with the schedule established by the EPSDT: Medical and Dental Protocol and Periodicity Schedules found in Appendix W of all MassHealth provider manuals, per 130 CMR 450.141.

For specialty care: Within appropriate time frames agreed to by EOHHS.

For Enrollees newly placed in the care or custody of DCF, who do not otherwise have emergent or Urgent Care needs:

Within seven calendar days of receiving a request from a DCF case worker, a DCF Health Care Screening shall be offered at a reasonable time and place. Such DCF Health Care Screening shall attempt to detect life threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse;

Within 30 calendar days of receiving a request from a DCF case worker, a comprehensive medical examination, including all age appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

For Poststabilization Care Services: Enrollees are provided with any necessary referrals for Poststabilization Care Services.

For all other services: In accordance with usual and customary community standards.

**Payment Reform Initiative**

Beginning Contract Year Four the Contractor shall be responsible for activities supporting the transformation to practice-based care from plan based care management, including support for MassHealth alternative payment initiative. The Contractor will deliver the following services related to Transformation and Integration of Care:

1. Contractor Support for practices participating in the Primary Care Payment Reform Initiative (PCPR), including:
    a. Qualitative evaluation of progress towards implementing patient-centered medical homes and behavioral health integration;
    b. Consulting with PCPR practices on practice identified opportunities related to behavioral health integration; and
    c. Reporting of Behavioral Health data related to PCPR panel enrollees to assist practices in managing under the PCPR payment model.
2. Support for evolving all PCCs capacity and competencies related to Behavioral Health Integration, including:
    a. Baseline assessment of levels of behavioral health integration throughout PCC Plan Network using simple, standardized survey consistent with AHRQ lexicon; and

   b. Delivery of practice consultation and provider education tailored to different levels of integration and related to financing, practice design, and workforce development for integrated care.

3. Support for the implementation of new initiatives related to PCCs, including by partnering directly with EOHHS in the design and introduction of such programs as they pertain to Transformation and Integration.

**Integrated Care Management Program**

1. Practice Based Care Management
   Beginning Contract Year Four, provide support to the ICMP team and assist with the expansion of the Practice Based Care Management Program (PBCM) in all regions, including providing technical assistance, compliance monitoring, dissemination and review of reports as directed by EOHHS and training/education as described in **Section 5.3.**

2. Plan Based Care Management
   Within two months of Contract Year Four, submit for approval a work plan that includes collaborating with PCC sites to gather information on preferred communication materials and information from the Contractor regarding the ICMP. Liaison with PCC practices to provide ICMP clinical records to practice on-site or by fax, in coordination with ICMP clinical staff. See **Section 5.3**

3. Education and Training
   PCC Plan PPSS will be responsible for the coordination of educational and training opportunities for PCCs and PBCMs. PCC Plan PPSS will collaborate with stakeholders and subject matter experts both internally and externally to identify relevant training topics that will support current and future EOHHS initiatives. These include:

   a. Conducting two webinars during Contract Year Four, addressing topics related to behavioral integration, care coordination, or other topics as approved by EOHHS; and

   b. Establishing and implementing educational opportunities, such as learning collaboratives, regional learning sessions, or other educational modes that support PCCs and PBCMs to engage in group learning and identified topics.

4. Other Activities Related to PCC Plan Support Including, but Not Limited to:

   a. PCC Plan PPSS representing the PCC Plan and EOHHS with respect to PCC Plan activities, at provider conferences, community agency meetings and other forums that require a PCC Plan presence, if requested or approved by EOHHS; and

   b. Establishing relationships with other EOHHS contractors (e.g. the Customer Service vendor) and referring PCCs to them in order to resolve questions and issues such as eligibility, claims and billing inquiries, provide file updates.

## PCC Plan MSS Support Material

1. Within two months of Contract Year Three, the Contractor shall:
   a. Develop and produce a web-based Health Literacy Library to meet the diverse needs of the PCC Plan population for use by members, PCCs and BH providers.
   b. Beginning Contract Year Four, the Contractor shall continue to develop and update the Health Literacy Library as directed by EOHHS staff. Topics shall clearly and concisely describe relevant health education, including medical, behavioral health, substance use, wellness/prevention topic areas and the Contractor, when appropriate, will submit new or updated materials to EOHHS for prior approval.
   c. Beginning Contract Year Four, the Contractor will review with EOHHS the current PCC Plan PPSS Support Materials, at EOHHS request, to determine additional and/or replacement Support Material necessary to support improved Member experience and integration of physical and behavioral health care. The Contractor shall deliver materials for EOHHS approval within required timeframes, as determined by EOHHS.
   d. Provide storage to accommodate all of the PCC Plan PPSS Support Materials necessary to meet the needs of the Network Providers and PCC network.
   e. Maintain a sample original package of all PCC Plan PPSS Support Materials and an inventory of all PCC PPSS Support Materials including:
      1) A list of topics for which PCC Plan PPSS Support Materials are available; and
      2) The number of each item in the Contractor's inventory of PCC Plan PPSS Support Materials.

2. PCC Compliance With PCC Provider Contract With EOHHS

   The Contractor shall:

   1. Develop and propose to EOHHS for review and approval a process for annually reviewing the compliance of selected PCCs with certain identified requirements in their PCC Provider Contracts (**Appendix C-2**), as well as other requirement specified by EOHHS;
   2. Annually submit a report to EOHHS documenting the process used to monitor compliance of those PCCs identified in **subsection 1** with the PCC Provider Contract and Contractor's finding regarding PCC compliance;
   3. Assist PCC Plan staff with ensuring that all providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and
   4. Perform all follow-up activities in connection with **subsection 3**, as directed by EOHHS."

### Care Management Program (CMP)