Addendum to Contract Between

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

In Partnership with

The Commonwealth of Massachusetts

and

Commonwealth Care Alliance, Inc.
Tufts Health Public Plans, Inc.

Issued: June 11, 2018

This Contract, effective July 16, 2013, and amended by addendum effective September 10, 2014 and January 7, 2015, amended and restated effective December 28, 2015, amended by addendum effective July 5, 2016, is hereby amended by addendum effective June 11, 2018, and is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (EOHHS) and _____ (the Contractor). The Contractor's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible, in relevant part, for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, the Massachusetts Executive Office of Health and Human Services is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et. seq., and M.G.L. c. 118E, designed to pay for medical services for eligible individuals;

WHEREAS, the Contractor is in the business of providing medical services, and CMS and the Massachusetts Executive Office of Health and Human Services desire to purchase such services from the Contractor;

WHEREAS, the continued provision of covered services contributes to the health and welfare of Enrollees;

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to amend the Contract;

WHEREAS, the term of the Contract is being extended pursuant to 801 CMR 21.05(5)(b) for the period necessary for EOHHS to complete its new procurement for the services set forth in the Contract;

WHEREAS, the CMS Medicare plan application process will begin in the fall of 2018 and must be completed for new Medicare-Medicaid plans to enroll eligible individuals and provide covered services for a contract effective date of January 1, 2020;

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

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

1. This Addendum deletes the definition for "Demonstration Year" in **Section 1** and replaces it with the following definition:

   "Demonstration Year — Demonstration Year 1 runs from the first Effective Enrollment Date through December 31, 2014; Demonstration Year 2 runs from January 1, 2015 through December 31, 2015; Demonstration Year 3 runs from January 1, 2016 through December 31, 2016; Demonstration Year 4 runs from January 1, 2017 through December 31, 2017; Demonstration Year 5 runs from January 1, 2018 through December 31, 2018; and Demonstration Year 6 runs from January 1, 2019 through December 31, 2019."

2. This Addendum deletes **Subsection 4.1.B** and replaces it with the following **Subsection 4.1.B**:

   "B. Demonstration Year Dates

   Capitation Rate updates will take place on January 1st of each calendar year. However, savings percentages and quality withhold percentages (see **Sections 4.2.C.1** and **4.3.D**) will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	First Effective Enrollment Date – December 31, 2014
2	January 1, 2015 – December 31, 2015
3	January 1, 2016 – December 31, 2016
4	January 1, 2017 – December 31, 2017
5	January 1, 2018 – December 31, 2018
6	January 1, 2019 – December 31, 2019"

3. This Addendum deletes **Subsection 4.2.C.1** and replaces it with the following **Subsection 4.2.C.1**:

   "1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the MassHealth Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with **Section 4.3.C.3**.

      a. Demonstration Year 1, as divided into the following two time periods:

         (1) First six months following the first Effective Enrollment Date: 0%

         (2) After the first six months following the first Effective Enrollment Date through December 31, 2014: 1%

b. Demonstration Year 2: 0%

c. Demonstration Year 3: 0%

d. Demonstration Year 4: 0.25%

e. Demonstration Year 5: 0.50%

f. Demonstration Year 6: 0.50%

4. This Addendum deletes **Subsection 4.3.D.6** and replaces it with the following **Subsection 4.3.D.6**:

"6. Withhold Measures in Demonstration Years 2 - 6

a. The quality withhold will be 0% in Demonstration Year 2 and 1% in Demonstration Year 3.

b. The quality withhold will be 1.25% in Demonstration Year 4, 1.50% for Demonstration Year 5, and 1.75% in Demonstration Year 6.

c. Payment will be based on performance on the quality withhold measures listed in **Figure 4.2**, below.

Figure 4.2: Quality Withhold Measures for Demonstration Years 2 through 6

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Getting Appointments and Care Quickly (for DY 2 only)	Percent of the best possible score the plan earned on how quickly members get appointments and care: • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Customer Service (for DY 2 only)	Percent of best possible score the plan earned on how easy it is to get information and help when needed: • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Plan all-cause readmissions	The ratio of the plan's observed readmission rate to the plan's expected readmission rate. The readmission rate is based on the percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Part D medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Initiation and engagement of alcohol and other drug dependence treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS		X
Adults' access to preventive/ambulatory health services (starting in DY 3)	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	NCQA/HEDIS		X
Encounter data (starting in DY 3)	Encounter data submitted accurately and completely in compliance with Contract requirements.	CMS/State defined process measure	X"	

5. In **Subsection 4.6** this Addendum revises the sentence "Risk corridors will be established for Demonstration Years 1 through 5" to read:

   "Risk corridors will be established for Demonstration Years 1 through 6."

6. This Addendum adds a new **Subsection 4.6.B.2.d** as follows and amends the numbering of the subsequent subsections accordingly:

   "d. Demonstration Year 6

(1) For the portion of gains and/or losses of 0 through 2.0%, the Contractor bears 100% of the gain/loss. For the portion of gains and/or losses of 2.1% through 8.0%, the Contractor bears 50% of the gain/loss and EOHHS and CMS share in the other 50%, as described in **Section 4.6.B.1**. For the portion of gains and/or losses of 8.1% and greater, the Contractor bears 100% of the gain/loss.

(2) For Risk Corridor Percentages greater than 108.0%, EOHHS and CMS will make payment to the Contractor of 3.0% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is at full financial risk for amounts greater than 108.0%.

(3) For Risk Corridor Percentages of 102.1 through 108.0%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 102.0%], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.

(4) For Risk Corridor Percentages of 98.0% through 102.0%, no payment will be made by EOHHS and CMS to the Contractor, or by the Contractor to EOHHS and CMS.

(5) For Risk Corridor Percentages of 97.9% through 92.0%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [98.0% minus the Risk Corridor Percentage], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.

(6) For Risk Corridor Percentages less than 92.0%, the Contractor will make payment to CMS and EOHHS of 3.0% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is not obligated to make any additional payment for amounts below 92.0%."

7. This Addendum adds **Subsection 4.6.B.3.d** as follows:

"d. Demonstration Year 6

Incremental Loss or Gain (as % of Total Adjusted Capitation Rate Revenue)[1]	**Corresponding Risk Corridor Percentage**	**% Contractor Risk Sharing**	**% EOHHS & CMS Risk Sharing**	**% CMS Risk Sharing**	**% EOHHS Risk Sharing[2]**
Loss >8%	>108.0%	100%	0%	0%	0%

Loss >2% and ≤ 8%	102.1% to 108.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Loss or Gain ≤ 2%	98.0% to 102.0%	100%	0%	0%	0%
Gain >2% and ≤ 8%	97.9% to 92.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Gain >8%	< 92.0%	100%	0%	0%	0%"

[1] Loss and gain reflected on an incremental basis, rounded to the nearest one tenth of a percent. Loss or gain >8.0% still results in risk sharing reconciliation for the loss or gain between 2.1% and 8.0%.

[2] All EOHHS Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

8. This Addendum deletes **Subsection 5.7** and replaces it with the following **Subsection 5.7**:

"**5.7 Contract Term**

This Contract shall be in effect through December 31, 2018, and, so long as the Contractor has not provided CMS with a notice of intention not to renew, and CMS/EOHHS have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above, shall be renewed in one year terms, through December 31, 2019."

In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

_____ _____

(Insert Contractor Signatory Name and Title) (Date)

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In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Richard McGreal (Date)

Associate Regional Administrator

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Kathryn Coleman (Date)

Director

Medicare Drug & Health Plan Contract Administration Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Marylou Sudders	(Date)
Secretary	
Executive Office of Health and Human Services	
Commonwealth of Massachusetts	

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