ATTACHMENT A

MASSHEALTH SENIOR CARE OPTIONS

CONTRACT FOR SENIOR CARE ORGANIZATIONS

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

TBD

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APPENDICES

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

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

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

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

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

SECTION 1. DEFINITIONS OF TERMS

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

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

Appeal – An Enrollee's request for formal review of an action of the Contractor in accordance with **Section 2.9** of the Contract.

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

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

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

Complaint - an Enrollee's informal oral or written expression of grievance or dissatisfaction with any aspect of his or her care, in accordance with **Subsection 2.8** of the Contract.

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

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

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

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

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

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

Covered Services - those services listed in **Appendix A** of the Contract delivered in accordance with **Subsection 2.4** of the Contract.

Cultural Competence - a set of congruent policies that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups including, but not limited to, ASL using deaf, hard-of-hearing and deaf blind persons. 'Competence' is the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Consumers and their communities, as defined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care.

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

Dual Eligible Senior – a senior, aged 65 or older, who is eligible and enrolled in Medicare Parts A and B with MassHealth Standard coverage.

Eligibility Verification System (EVS) [formerly known as the Recipient Eligibility Verification System (REVS)] - the online and telephonic system Providers must access to verify eligibility, managed care enrollment, and available third party liability information about Members.

Emergency Condition - a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. An Emergency Condition may not be limited on the basis of lists of diagnoses or symptoms.

Enrollee - a MassHealth Member who voluntarily enrolls with a Contractor.

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

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

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

Functional Status - measurement of the ability of individuals to perform Activities of Daily Living (ADLs) (for example, mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and

Instrumental Activities of Daily Living (IADLs) (for example, meal preparation, laundry, and grocery shopping).

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

Geriatric Support Services Coordinator (GSSC) - an employee of an ASAP who meets the qualifications listed in **Subsection 2.4(A)(5)** of the Contract.

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.

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.

Individualized Plan of Care (IPC) - a detailed written description of the scope, frequency, and duration, of all Covered Services to be provided by the Contractor to an Enrollee.

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

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

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

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

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

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

Minimum Data Set - a clinical screening system, mandated by federal law for use in nursing facilities that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.

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

Ongoing Assessment - a re-evaluation of an Enrollee's health status conducted in accordance with **Subsection 2.4(A)(11)** of the Contract.

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

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

Prevalent Languages – As determined by EOHHS and the Contractor, those languages spoken by a significant percentage of Enrollees in each Region in which the Contractor is contracted by EOHHS to operate.

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

Primary Care Physician (PCP) - a licensed physician who is able and willing to meet all of the PCP requirements in **Subsection 2.4(B)** of the Contract.

Primary Care Team (PCT) - a team consisting of a PCP working in conjunction with a GSSC, a nurse practitioner, a registered nurse, or physician's assistant, all of whom must have experience in geriatric practice. To assure effective coordination and delivery of care, the PCT may be enlarged at the discretion of the PCP to include other professional and support disciplines.

Program of All-Inclusive Care for the Elderly (PACE) – a comprehensive service delivery and financing model that integrates medical and long term care services under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE Service Area.

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

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

Quality Management Goals - annual goals negotiated by the Contractor and EOHHS to improve the Contractor's performance under the Contract. Improvement Goals are incorporated into **Subsection 2.10** of the Contract.

Rate Cells (also known as Rating Categories) (RCs) - the categories used by MassHealth to calculate capitation payments. MassHealth RCs take into account clinical status and whether the Enrollee resides in or outside Greater Boston. The RC system includes payment for institutional and community-based Enrollees. Institutional and community groups are further divided according to the specific clinical needs and status of Enrollees.

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

Senior Care Organization (SCO) – the Contractor.

Service Area - the specific geographical area of Massachusetts for which the Contractor agrees to provide Covered Services to all Enrollees who select the Contractor.

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

State – the Commonwealth of Massachusetts.

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

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

SECTION 2. CONTRACTOR RESPONSIBILITIES

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

Section 2.1 Compliance

Prior to commencing the initial enrollment of members, the Contractor must demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs Plan for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority. Failure on the part of the Contractor to demonstrate this designation will be grounds for contract termination pursuant to **Section 5.7**.

The Contractor must comply, to the satisfaction of EOHHS, with all provisions set forth in this Contract, as well as Medicare Advantage program requirements in Part C and Part D of Title XVIII, 42 CFR Part 433 and all provisions of applicable law.

Section 2.2 Contract Management

A. Director of the Contractor's Senior Care Options Program

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

B. SCO Director Responsibilities

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

1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the SCO RFR and approved by EOHHS and CMS (etc.);
3. Oversee all activities by the Contractor and its Subcontractors, including but not limited to, coordinating with the Contractor's quality management director, medical director, geriatrician, and behavioral health clinician;
4. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least 30 days before the intended effective date of the change;

5. Receive and respond to all inquiries and requests made by EOHHS and CMS, in time frames and formats reasonably acceptable to the three parties;

6. Meet with representatives of EOHHS or CMS, or both, on a periodic or as-needed basis and resolving issues that arise;

7. Ensure the availability to EOHHS or CMS, upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management-information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, utilization management, Provider-Network management, and benefit coordination;

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

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

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

11. Meet with EOHHS and CMS at the time and place requested by EOHHS and CMS, if EOHHS or CMS, or both, determine that the Contractor is not in compliance with the requirements of the Contract; and

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

Section 2.3 Enrollment Activities

Enrollment in the Senior Care Options Program is voluntary. In accordance with **Section 2.1**, prior to commencing the initial enrollment of members, the Contractor must demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority.

A. Enrollment

1. The Contractor must accept Enrollees in the order in which they apply, without restrictions, regardless of income status, physical or mental condition, age (as long as eligibility requirements are met), gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, ancestry, pre-existing conditions, or expected health status, in accordance with federal and State requirements.
2. The Contractor may, on behalf of a MassHealth Member, submit enrollments and disenrollments. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS, and must maintain on file such forms that are signed by Enrollees.
3. EOHHS will assign Rate Cells (RCs) upon enrollment. For certain RCs, the Contractor must submit a request, including documentation supporting the requested RC. For additional information on RCs, see **Section 4**.
4. Enrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month.
5. The Contractor will be responsible for providing Covered Services to Enrollees from the effective date of enrollment.
6. The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor's program, including the effective date of enrollment, from CMS and EOHHS systems.

B. PCPs

1. PCP Selection

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

2. Termination of a PCP

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

C. Initial Assessment

The Contractor must complete an Initial Assessment within 30 calendar days of an Enrollee's selection of a PCP. If the Enrollee is in an institution or institutional placement is pending, the Contractor must complete an Initial Assessment within five business days. The Initial Assessment must include:

1. An evaluation of clinical status, Functional Status, nutritional status, and physical well-being;
2. The medical history, including relevant family members and illnesses;
3. Screenings for mental-health status, and tobacco, alcohol and drug use; and
4. An assessment of the need for long term care services, including the availability of informal support.

D. Enrollee Orientation

The Contractor must:

1. Provide an orientation to Enrollees within 30 calendar days of the initial date of enrollment;
2. Make available to family members, significant informal caregivers, and designated representatives, as appropriate, any enrollment and orientation materials upon request;
3. For Enrollees for whom written materials are not appropriate, provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations;
4. Notify its Enrollees:
    a. That written information is available in Prevalent Languages;
    b. That oral interpretation services are available for any language;
    c. How Enrollees can access oral interpretation services; and
    d. How Enrollees can access non-written materials described in **Subsection 2.3(D)(3)** above.
5. Ensure that all orientation materials are provided in a manner and format that may be easily understood, including oral interpretation services in all non-English languages when requested. Orientation materials must include the following:
    a. A list of Covered Services;
    b. A Provider Network directory;

c. A description of the roles of the PCP and PCT and the process by which Enrollees select and change PCPs;

d. The Contractor's Evidence of Coverage (see **Appendix B**) including, but not limited to, descriptions of:

1) Enrollee rights;

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

3) How to obtain a copy of the Enrollee's Centralized Enrollee Record;

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

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

6) Information about advance directives (at a minimum those required in 42 CFR 489.100), designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desires of the Enrollee;

7) How to obtain assistance from ESRs;

8) How to file Complaints and Appeals with the Contractor;

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

10) How to obtain assistance with the Medicare and Medicaid Appeals processes through the ESR and External Ombudsman; and

11) How to disenroll voluntarily.

E. Disenrollment

The Contractor must:

1. Have a mechanism for receiving timely information about all disenrollments from the Contractor's program, including the effective date of disenrollment, from CMS and EOHHS systems. Disenrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month;
2. Be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment;
3. Request that an Enrollee be involuntarily disenrolled for the following reasons *only*:
    a. Loss of MassHealth eligibility;
    b. Remaining out of the Service Area for more than six consecutive months; and
    c. If approved in advance by EOHHS, when the Contractor's ability to furnish services to the Enrollee or to other Enrollees is seriously impaired.
4. Transfer Enrollee record information to the new Provider upon written request signed by the disenrolled Enrollee; and
5. Collect reasons for voluntary disenrollment, as required in **Subsection 2.14(E)**.

F. Closing Enrollment

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

Section 2.4 Care Management and Integration

A. General

1. Service Delivery

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

2. Primary Care Physician (PCP) Selection

   The Contractor must ensure that each new Enrollee selects a PCP upon the effective date of enrollment.

3. Accepting and Processing Assessment Data

   For the purposes of quality management and Rating Category determination, the Contractor must accept, process, and report to EOHHS uniform person-level Enrollee data, based upon an Initial and Ongoing Assessment process that includes ICD-9 diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0), and any other data elements deemed necessary by EOHHS.

4. Assessment and Determination of Complex Care Needs

   Upon enrollment, and as appropriate thereafter, the Contractor must perform Initial and Ongoing Assessments, using an assessment tool approved by EOHHS. This process will identify all of an Enrollee's needs, and, in particular, the presence of Complex Care Needs.

5. Geriatric Support Services Coordinator (GSSC)

   a. The Contractor must establish its own written qualifications for a GSSC and provide a GSSC through a contract with one or more of the ASAPs designated by the Executive Office of Elder Affairs that operate in the Contractor's Service Area. If more than one ASAP is operating in the Contractor's Service Area, the Contractor may:

      1) Contract with all of the ASAPs; or

      2) Contract with a lead ASAP to coordinate all the GSSC work in the Contractor's Service Area.

   b. The GSSC is responsible for the following activities:

      1) As a member of the PCT, participate in Initial and Ongoing Assessments of the health and Functional Status of Enrollees, including determining appropriateness for institutional long term

care services and developing community-based care plans and related service packages necessary to improve or maintain Enrollee health and Functional Status;

2) Arrange and, with the agreement of the PCT, coordinate and authorize the provision of appropriate community long term care and social support services (such as assistance with the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), housing, home-delivered meals, and transportation) and, under specific conditions or circumstances established by the Contractor, authorize a range and amount of community-based services;

3) Monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the PCT; and

4) Track the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the PCT.

c. The Contractor must follow the procedure in **Subsection 2.4(A)(5)(e)**, if the Contractor identifies any of the following deficiencies:

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

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

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

d. The Contractor and an ASAP may enter into any appropriate reimbursement relationship for GSSC services, such as fee-for-service reimbursement, capitation, or partial capitation. If the Contractor is unable to execute or maintain a contract with any of the ASAPs operating in its Service Area due to lack of agreement on reimbursement-related issues, the Contractor must collaborate with EOHHS and the Office of Elder Affairs to explore all reasonable options for reconciling financial differences, before terminating or failing to initiate a contract. If the Contractor terminates or fails to initiate a contract with an ASAP

operating in its Service Area, the Contractor must follow the procedure in **Subsection 2.4(A)(5)(e)**.

e. If the Contractor determines that it must terminate a GSSC contract with an ASAP, the Contractor must notify EOHHS in writing, within five business days of the decision to terminate, with detailed specific findings of fact that indicate the deficiencies. If EOHHS finds that the Contractor's reasons are not substantiated with sufficient findings, EOHHS will develop a corrective action plan for the Contractor that ensures continuation of GSSC services and specifies the actions the Contractor will take.

f. The Contractor may also enter into a subcontracting relationship with any ASAP for functions beyond those of the GSSC including, but not limited to:

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

2) Arranging and coordinating the completion of the MDS-HC forms required for determination of RC; and

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

6. Integration and Coordination of Services

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

a. An Individualized Plan of Care for each Enrollee, signed by the Enrollee or the Enrollee's representative, developed by the PCP or, if applicable, the PCT, and the periodic review and modification of this treatment plan by the PCP or PCT;

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

c. Written protocols for providing or arranging for second opinions, whether in or out of network;

d. Written protocols for sharing clinical and Individualized Plan of Care information, including management of medications;

e. Written protocols for determining conditions and circumstances under which specialty services will be provided appropriately and without undue delay to Enrollees who do not have established Complex Care Needs (for example, GSSC and specialty physician services);

f. Written protocols for tracking and coordination of Enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult day health) and ensuring continued provision of necessary services; and

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

7. Coordinating Access for Emergency Conditions and Urgent Care Services

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

a. Any services for Emergency Conditions;

b. Emergency behavioral health care;

c. Urgent Care sought out of the Service Area;

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

e. Direct-access women's services; and

f. Out-of-area renal dialysis services.

8. Centralized Enrollee Record

To coordinate care, the Contractor must maintain a single, centralized, comprehensive record that documents the Enrollee's medical, functional, and social status. The Contractor must ensure that the PCP and all members of the PCT as well as any other appropriate Providers, including subcontracted Providers, make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The organization and documentation included in the Centralized Enrollee Record must meet all applicable professional requirements. The Centralized Enrollee Record must contain the following:

a. Enrollee identifying information;

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

c. Multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate Provider;

d. Laboratory and radiology reports;

e. Prescribed medications, including dosages and any known drug contraindications;

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

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

h. Physician orders;

i. Disenrollment agreement, if applicable;

j. Enrollee's individual advance directives and health care proxy, recorded and maintained in a prominent place;

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

l. Allergies and special dietary needs.

9. Requirements for Centralized Enrollee Record Information

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

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

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

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

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

a) Enrollee information;

b) Clinical information;

c) Clinical assessments;

d) Treatment plans;

e) Treatment/services provided;

f) Contacts with Enrollees' family, guardians, or significant others; and

g) Treatment outcomes.

b. The Contractor shall implement systems to ensure that the Centralized Enrollee Record is:

1) Updated in a timely manner by each Provider of care;

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

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

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

10. Confidentiality of Centralized Enrollee Record Information

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

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

b. Informing Enrollees how to obtain a copy of their Centralized Enrollee Record and how to request that it be amended or corrected;

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

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

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

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

11. Frequency of Assessments

The Contractor must:

a. Record the results of all assessments in the Centralized Enrollee Record and communicate the results to the Enrollee's Provider Network in a timely manner; and

b. Perform Ongoing Assessments of each Enrollee's needs:

1) At least once every six months, or

2) For Enrollees who require Complex Care, at least quarterly, or

3) Whenever an Enrollee experiences a major change that is:

a) Not temporary;

b) Impacts more than one area of health status; and

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

12. Coordinating Services with Federal, State, and Community Agencies

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

1) State agencies (for example, the Executive Office of Elder Affairs, the Department of Public Health, the Department of Developmental Services, and the Department of Mental Health);

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

3) Consumer, civic, and religious organizations; and

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

b. The systematic process and associated linkages must provide for:

1) Sharing information and generating, receiving, and tracking referrals;

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

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

13. Consumer Participation on Governing and Advisory Boards

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

14. Authorization of Services

In accordance with 42 CFR 438.210, the Contractor and its Subcontractors, if applicable, must have in place, and follow, written policies and procedures for processing requests of initial and continuing authorization of services to ensure consistent application of review criteria for authorization decisions. These written policies and procedures shall include the following requirements:

a. 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 health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;

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

c. Require that in the event a Provider indicates, or the Contractor determines, that the timeframe described at **Section 2.4(A)(14)(b)** could seriously jeopardize an Enrollee's life or health or ability to attain, maintain or regain maximum function, the Contractor must make a service authorization decision and provide notice to the Enrollee as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the receipt of the request for service.

15. Utilization Management Activities

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

B. Primary, Acute, and Preventive Care

1. PCP Clinical Responsibilities

   The PCP must:

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

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

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

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

      3) Scheduling an Initial Assessment to begin within the first five business days of the effective date of enrollment;

      4) Scheduling Ongoing Assessments in accordance with **Subsection 2.4 (A)(11)(b)**;

      5) Providing primary medical services, including acute and preventive care; and

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

2. Care Management Responsibilities of the PCP or PCT

   As the manager of care, the PCP or the PCT must:

   a. With the Enrollee and the Enrollee's designated representative, if any, develop an Individualized Plan of Care, signed by the Enrollee or the Enrollee's designated representative, that includes treatment goals (medical, functional, and social) and measures progress and success in meeting those goals;

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

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

d. Conduct Ongoing Assessments appropriately, adjust Individualized Plans of Care as necessary, and communicate the information to the Enrollee's Providers in timely manner;

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

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

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

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

i. Communicate with the Enrollee, and the Enrollee's family members and significant caregivers, if any, about the Enrollee's medical, social, and psychological needs.

C. Long Term Care

1. Long Term Care Delivery System

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

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

b. The GSSC participates in determinations of appropriateness for institutional and community long term care services and identifies and recommends to the PCP which Enrollees may need a PCT; and

c. The measurement of the Functional Status of Enrollees is performed at Initial and Ongoing Assessments. Reports will be produced in accordance with **Subsection 2.14(F)**.

2. Continuum of Long Term Care

The Contractor must provide:

a. Community alternatives to institutional care (see **Appendix A**);

b. Other transitional, respite, and residential support services to maintain Enrollees safely in the community, based on assessment by the Contractor of Functional Status and cost effectiveness;

c. Nursing facility services for Enrollees who meet applicable screening requirements (in accordance with 130 CMR Chapter 456 and Chapters 515 through 524) and for whom the Contractor has no noninstitutional service package appropriate and available to meet the Enrollee's medical needs (see **Subsection 2.14(H)** for reporting requirements); and

d. Other institutional services as determined by the PCT.

3. Pre-Admission Screening and Annual Resident Review (PASARR) Evaluation

The Contractor must comply with federal regulations requiring referral of nursing facility eligible Enrollees, as appropriate, for PASARR evaluation for mental illness and mental retardation treatment pursuant to OBRA '87.

D. Behavioral Health

1. Systematic Early Identification and Intervention for Behavioral Health Services

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

2. Services for Enrollees with Serious and Persistent Mental Illness

The Contractor must ensure that Enrollees with serious and persistent mental illness have access to ongoing medication review and monitoring, day treatment, and other milieu alternatives to conventional therapy. The PCT must coordinate services with additional support services as appropriate. For such Enrollees, a qualified behavioral health clinician (see **Subsection 2.5(B)**) must be part of the PCT. As necessary, care coordination with the Department of Mental Health must be provided.

3. Continuum of Behavioral Health Care

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

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

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

4. Behavioral Health Responsibilities

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

a. With the Enrollee and the Enrollee's designated representative, if any, develop the behavioral health portion of the Individualized Plan of Care for each Enrollee in accordance with accepted clinical practice and obtain the signature of the Enrollee or the Enrollee's designated representative, if any;

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

c. Make appropriate and timely entries into the Centralized Enrollee Record about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and Individualized Plan of Care developed. As stated in **Subsection 2.4(A)(10)(d),** psychotherapeutic session notes must not be recorded in the Centralized Enrollee Record; and

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

5. Coordination of Medication

Prescriptions for any psychotrophic medications must be evaluated for interactions with the medications already prescribed for the Enrollee. (See **Subsection 2.14(A)(2)**.)

6. Behavioral Health Needs Management

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

E. Health Promotion and Wellness Activities

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

1. Exercise
2. Preventing falls;
3. Adjustment to illness-related changes in functional ability;
4. Adjustment to changes in life roles;
5. Smoking cessation;
6. Nutrition;
7. Prevention and treatment of alcohol and substance abuse; and
8. Coping with Alzheimer's disease.

Section 2.5 Provider Network

A. General

1. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required under this Contract (see Covered Services in **Appendix A**). The Contractor must notify EOHHS of any Provider Network changes within five business days.
2. If the Contractor declines to include individuals or groups of Providers in its Provider Network, the Contractor must give the affected Providers written notice of the reason for its decision. Pursuant to 42 CFR 438.12(b) this requirement may not be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees, or preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or to preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs consistent with its responsibilities to Enrollees.
3. The Contractor must comply with the requirements specified in 42 CFR 438.214, which includes selection and retention of Providers, credentialing and recredentialing requirements, and nondiscrimination.
4. The Contractor may use different reimbursement amounts for different specialties and for different practitioners in the same specialty.
5. The Contractor may not employ or contract with Providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act.

B. Provider Qualifications and Performance

1. Written Provider Protocols

   The Contractor must have and comply with written protocols in the following areas:

   a. Credentialing, re-credentialing, certification, and performance appraisal processes that demonstrate that all members of the Provider Network maintain current knowledge, ability, and expertise in the service or specialty in which they practice. Providers must meet board certification, continuing education, and other requirements, as appropriate, including 42 CFR 493.1 and 493.3. The protocol must also include: Enrollee Complaints and Appeals; results of quality reviews; utilization management information; and Enrollee surveys;

   b. Practice guidelines, in accordance with 42 CFR 438.236;

c. Continuing education programs for PCTs, specialty Providers, behavioral health Providers, and long term care Providers to ensure they are knowledgeable about and sensitive to the health care needs of Enrollees. Education must also be provided about quality management activities and requirements;

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

1) Mechanisms for detecting both underutilization and overutilization of services;

2) Resource utilization of services, including specialty and ancillary services;

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

4) Interdisciplinary team performance, including resolution of service plan disagreements;

5) Enrollee experience and perceptions of service delivery; and

6) Timely access.

e. A corrective action process for Providers whose performance is unacceptable in one or more of the areas noted in **Subsection 2.5(B)(1)(d)** above. For serious Complaints involving medical Provider errors, the Contractor must take immediate corrective action and file reports of corrections made with the CMS and EOHHS within three business days of the Complaint.

2. Primary Care Qualifications

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

a. PCP

The PCP must:

1) Be licensed by the Massachusetts Board of Registration in Medicine;

2) Be either board-certified or board-eligible in Family Practice or Internal Medicine or be further certified in Gerontology or Geriatric Medicine;

3) Obtain annual continuing medical education units in geriatric practice;

4) Have at least two years' experience in the care of persons over the age of 65; and

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

Note: Upon formal application to EOHHS by the Contractor, on behalf of individual physicians who have specialized expertise (long term care, behavioral health, etc.) or abilities (linguistic, cultural, etc.) which meet the needs of particular groups of Enrollees, EOHHS may waive the requirements set forth in subsections (2) and (4) above.

b. Registered Nurse or Nurse Practitioner

The registered nurse or nurse practitioner member of the PCT must be:

1) Licensed by the Massachusetts Board of Registration of Nursing, with annual continuing education units in geriatric practice; and

2) Certified as a geriatric nurse practitioner or demonstrate at least two years' professional experience in the care of persons over the age of 65.

c. Physician Assistant

The physician assistant member of the PCT must:

1) Be licensed by the Board of Registration of Physician Assistants; and

2) Demonstrate at least two years' professional experience in the care of persons over the age of 65.

d. GSSC

The GSSC must:

1) Either be a social worker employed by an ASAP and licensed by the Commonwealth of Massachusetts, with annual continuing education units in geriatric practice; ***or*** have at least a baccalaureate degree and two years' professional experience in the

care of persons over the age of 65, with at least one year involving work in a setting where persons over 65 receive health-care services (such as a hospital, nursing facility, a community health agency, or interdisciplinary program within an ASAP); and

2) Have the knowledge and skills necessary to work successfully in the interdisciplinary team and to provide or arrange for community long term care, as defined in **Subsection 2.4(C)(2).**

3. Subcontracting Requirements

The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

The Contractor is responsible for the satisfactory performance and adequate oversight of its Subcontractors. Subcontractors are required to meet the same federal and State financial and program reporting requirements as the Contractor. Additional information about subcontracting requirements is contained in **Appendix C**.

The Contractor must:

a. Establish contracts and other written agreements between the Contractor and subcontracting Providers for Covered Services not delivered directly by the Contractor or its employees;

b. Contract only with qualified or licensed Providers who continually meet federal and State requirements, as applicable, and the qualifications contained in **Appendix C;** and

c. Include a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the Subcontractor, in accordance with federal and State requirements.

C. Provider Training

The Contractor must:

1. Inform its Provider Network about the program, including all Covered Services contained in **Appendix A**;
2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services through the provision of a Provider-training curriculum, flow charts, and other written materials to enhance coordination and linkage;

3. Inform its Provider Network about the procedures and timeframes for Enrollee Complaints and Enrollee Appeals;

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

    a. Identification and management of depression, alcohol abuse, and Alzheimer's disease;

    b. Identification and treatment of incontinence;

    c. Preventing falls;

    d. Identification of abuse and neglect of elderly individuals; and

    e. Coordination of care within the Provider Network, including instructions regarding policies and procedures for maintaining the Centralized Enrollee Record.

5. Instruct and assist its Provider Network in verifying each Enrollee's MassHealth eligibility from the Eligibility Verification System (EVS) before providing services (except for services for Emergency Conditions), without resulting in discrimination against the Enrollee.

D. Provider Network Directory

1. Maintenance and Distribution

    The Contractor must:

    a. Maintain a Provider Network directory that identifies the Contractor's Provider Network, including at a minimum PCPs, behavioral health Providers, hospitals, specialty physicians, pharmacies, and ASAPs;

    b. Provide a copy to all new Enrollees and, upon request, to continuing Enrollees; and

    c. Provide Enrollees, CMS, and EOHHS with updated copies of its Provider Network directory on an annual basis.

2. Content of Provider Network Directory

    a. The Provider Network directory must include, at a minimum, the following information for all Providers in the Contractor's Provider Network:

        1) An alphabetical list of Providers; and

        2) A geographic list of Providers by town.

b. For the Contractor's PCPs and behavioral health Providers, the Provider Network directory must also include the following information:

1) Office address and telephone numbers;

2) Office hours;

3) Languages, other than English, spoken by Providers or by skilled medical interpreters at the Provider's site, and whether translation services are available;

4) The capacity for accepting new Enrollees; and

5) For behavioral health Providers only, qualifications and licensing information.

E. Intellectual Property

1. Contractor Property and License

a. The Contractor will retain all right, title and interest in and to all intellectual property developed by it, (i) for clients other than the Commonwealth, and (ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such work product (hereinafter the "Contractor Property"). EOHHS acknowledges that its possession or use of Contractor Property will not transfer to it any title to such intellectual property.

b. Except as expressly authorized in this Contract, EOHHS will not use, copy, modify, publicly display, publicly perform, distribute, transmit or transfer by any means, display, or sublicense the Contractor Property.

c. The Contractor grants EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works based upon the Contractor Property, in any media now k known or hereafter known, but only to the extent reasonably necessary for EOHHS's purposes pursuant to this Contract.

d. Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of the Contractor Property under the license created herein, the Contractor shall have all the rights and incidents of ownership with respect to the Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

2. EOHHS Property

a. In conformance with the Commonwealth Terms and Conditions, except for the Contractor Property, the Contractor acknowledges and agrees that any and all tasks, deliverables and other work product (which includes, but is not limited to, all reports, summaries, documentation, outlines, plans, processes, know-how, methodologies, layouts, presentations, designs, graphics, specifications, results, user manuals, training materials, work flows, data flows and content) created for or provided to EOHHS by the Contractor or, where applicable, any of its Subcontractors as a result of the Contractor's performance of the services described herein, or other obligation set forth in this Contract (collectively "EOHHS Property") are "works made for hire" as such term is defined in the U.S. Copyright Act, and all right, title and interest in the EOHHS Property shall belong to EOHHS. If any EOHHS Property is not subject to the "works made for hire" provisions of the Copyright Act, the Contractor hereby assigns, on behalf of itself and its Subcontractors, to EOHHS, all right, title and interest the Contractor or its Subcontractors may now have or hereafter acquire in and to all such EOHHS Property and the results of all services provided by the Contractor or its Subcontractors hereunder. The Commonwealth of Massachusetts and its assignees shall be the sole owner of all patents, copyrights, trademarks, trade secrets, and other rights and protection in the EOHHS Property. The Contractor agrees to assist EOHHS to obtain and enforce patents, copyrights, trademarks, trade secrets, and other rights and protection relating to such EOHHS Property, and, to that end, the Contractor shall execute all documents used in applying for and obtaining such patents, copyrights, trademarks, trade secrets and other rights and protection on and enforcing such EOHHS Property as EOHHS may desire, together with any assignments thereof to EOHHS.

b. To the extent that any Contractor or third-party intellectual property (collectively, the "Third Party Property") is contained in any EOHHS Property, the Contractor hereby grants to EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works of the Third Party Property. Nothing in the foregoing provisions restricts EOHHS from licensing the EOHHS Property or Third Party Property to the U.S. Department of Health and Human Services or any other federal or state agency in accordance with applicable regulations. The Contractor hereby represents and warrants that it has obtained all necessary rights and clearances and has the authority to grant the rights and licenses to t he EOHHS Property and the Third Party Property as described herein.

c. All data acquired by the Contractor from EOHHS or from others in the performance of this Contract (including personal data, if any) remain the property of EOHHS. The Contractor agrees to provide EOHHS free and full access at all reasonable times to all such data, regardless of whether the data is stored by the Contractor or, where applicable, its Subcontractors.

d. The Contractor shall not disseminate, reproduce, display or publish any EOHHS Property except in accordance with the terms and pursuant to its obligations under this Contract without the prior written consent of EOHHS.

e. The Contractor shall not use EOHHS-owned data, materials and documents, before or after termination or expiration of this Contract, except as required for the performance of the services thereunder.

f. The Contractor shall return to EOHHS promptly, but in any event no later than one week after EOHHS's request, EOHHS-owned or Commonwealth-owned data, and EOHHS Property. If such return is not feasible, the Contractor shall, at EOHHS's direction, destroy all EOHHS- or Commonwealth-owned data and/or EOHHS Property.

Section 2.6 Enrollee Access to Services

A. General

The Contractor must:

1. Demonstrate its ability to meet the needs of Enrollees competently and promptly;
2. Offer adequate choice and availability of PCPs and PCTs, if Complex Care Needs are present, as well as behavioral health and long term care Providers;
3. Provide adequate access to Covered Services (listed in **Appendix A**), including physical and geographic access. Such access must be designed to accommodate the needs of Enrollees who are disabled or non-English speaking, including access to TTY (for the deaf and hard of hearing) and translation services;
4. Provide all Covered Services in a manner that is no more restrictive than MassHealth fee for service; and is responsible for covering, at a minimum, all medically necessary services pursuant to 130 CMR 450.204; and
5. Comply with all federal requirements regarding the provision of services, including but not limited to 42 CFR 431.51(b)(2) and 42 CFR 441.202.

B. Proximity Requirements

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

C. Availability of Services

1. 24-Hour Coverage

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

        1) Has immediate access to the Centralized Enrollee Record (see **Subsection 2.4(A)(9)**);

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

        3) Has the experience and knowledge to provide clinical triage; and

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

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

2. Triage System

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

3. Access to Services for Emergency Conditions and Urgent Care

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

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

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

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

d. If services are obtained out of network for Emergency Conditions, the Contractor must pay the Provider or reimburse the Enrollee, in the fee-for-service amount that would have been paid by Medicare or MassHealth, within 60 calendar days after the claim has been submitted; and

e. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 CFR 438.114(c) and Mass. Gen. Laws c. 118E, §17A.

4. Urgent Care and Symptomatic Office Visits

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

5. Nonsymptomatic Office Visits

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

6. Choice of Long Term Care and Hospital Providers

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

D. Cultural Competence

The Contractor shall ensure that:

1. Multilingual Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations;
2. Network Providers and interpreters/transliterators are available for those who are deaf or hearing-impaired, to the extent that such capacity exists within the Contractor's Service Area; and
3. Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under the Contract.

E. Access for Enrollees with Disabilities

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

F. Access to Home- and Community-Based Services

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

Section 2.7 Enrollee Services

A. Enrollee Service Representatives (ESRs)

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

B. ESR Support Functions

ESRs must:

1. Be knowledgeable about MassHealth, Medicare, and all terms of the Contract, including the Covered Services listed in **Appendix A**;
2. Be available to Enrollees to discuss and provide assistance with resolving Enrollee Complaints; and
3. Compile and analyze all Complaints at least annually on the anniversary of the Contract start date. The analysis must include an examination of frequency by type of Complaint and the satisfaction or dissatisfaction of Enrollees with Complaint resolution.

C. Enrollee Service Telephone Responsiveness

ESRs must be available during normal business hours on a daily basis. The Contractor must answer 90% of all Enrollee telephone calls within 20 seconds or less. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question.

Section 2.8 Enrollee Complaints

An Enrollee Complaint is an Enrollee's informal written or oral expression of dissatisfaction with any aspect of his or her care. An Enrollee Complaint is different from an Enrollee Appeal, which is described in **Subsection 2.9**.

A. Complaint Filing

An Enrollee may file an Enrollee Complaint at any time by calling or writing the Contractor. The Contractor must inform Enrollees of the postal address or toll-free telephone number where an Enrollee Complaint may be filed.

B. Complaint Administration

The Contractor must have a system in place for addressing Enrollee Complaints. The system must meet the following standards:

1. Timely acknowledgement of receipt of each Enrollee Complaint;
2. Response, orally or in writing, to each Enrollee Complaint within a reasonable time, but no later than 30 days after the Contractor receives the Complaint; and
3. Availability to Enrollees of information about Enrollee Appeals, as described in **Subsection 2.9,** including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

Section 2.9 Enrollee Appeals

In accordance with 42 CFR 422 Subpart M, an Enrollee may Appeal any Contractor decision to deny, terminate, suspend, or reduce services. An Enrollee may also Appeal the Contractor's delay in providing or arranging for a Covered Service. A Provider acting on behalf of an Enrollee, and with the Enrollee's written consent, may file an Appeal. If the Contractor has not reached a service decision within the timeframes described at **Section 2.9(A)(1)**, the Contractor must give notice to the Enrollee. An untimely service decision constitutes a denial and is thus an adverse action. The Contractor must have written procedures that adhere to the following service decision/Appeals process. An Enrollee will continue to receive all services in place at the time of filing for the duration of the Appeal process.

A. Service Decisions

1. The Contractor must make a decision regarding an Enrollee's request for service within 14 calendar days of the request for service, or by the expiration of the extension as described in **Section 2.4(A)(14)(b)**. .
2. If the Contractor decides to terminate, suspend, or reduce a previously authorized Covered Service, the Contractor must notify the Enrollee of its decision at least ten days in advance of the date of its action. As part of its notice obligation, the Contractor must send the Enrollee a written notice at the time of its decision. The form and content of the notice must be approved by CMS and EOHHS. The written notice must state the reasons and inform the Enrollee of his/her right to file an Appeal. If a written notice is not received within five business days of the service request, the Enrollee may file an internal Appeal.
3. If the service decision regards a hospital discharge of an Enrollee covered by Medicare, the notice must explain the Quality Improvement Organization (QIO) Appeal process, which is outlined in **Subsection 2.9(D)**.

B. Internal Appeals

1. Filing an Internal Appeal

   If the Enrollee disagrees with the Contractor's decision, the Enrollee may file an internal Appeal by writing, faxing, or calling the Contractor within 60 calendar days of the receipt of the written denial notice. The Enrollee must follow an oral filing with a written signed Appeal within the 60-day limit, unless the Enrollee requests an expedited appeal decision in accordance with **Section 2.9.B.2.b**. A Provider acting on behalf of an Enrollee, and with the Enrollee's written consent, may file an internal Appeal. The Enrollee may also file an internal Appeal through the Social Security Administration or the Railroad Retirement Board, which will forward the Appeal to the Contractor. The 60-day limit may be extended at the discretion of the Contractor. Except for the circumstances described in **Subsection 2.9(C)(2)**, an Enrollee must first exhaust the Contractor's internal Appeal process under **Subsection 2.9(B)** before the Enrollee can proceed with an external Appeal under **Subsection 2.9(C)**.

2. Making an Internal Appeal Decision

As specified below, the Contractor must make an internal Appeal decision within appropriate timeframes. The Contractor must afford a reasonable opportunity for the Enrollee, or a designated representative, to present information orally or in writing during the internal Appeal process. The internal Appeal decision must be made by a physician who was not involved in the initial decision and who has appropriate expertise in the field of medicine for the services at issue. The Contractor must notify the Enrollee of its internal Appeal decision in writing and, for an expedited internal Appeal, the Contractor must also make reasonable efforts to provide oral notice.

a. Standard Internal Appeal Process

1) The Contractor must notify the Enrollee of the internal Appeal decision as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the Appeal. The Contractor may extend this time frame up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension of time benefits the Enrollee. When the Contractor takes an extension, the Enrollee must be notified in writing.

2) If the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the internal Appeal (or no later than the expiration of an extension).

b. Expedited Internal Appeal Process

1) The Enrollee has the right to request and receive an expedited Appeal decision affecting the Enrollee's medical treatment in a time-sensitive situation. The Enrollee must ask for an expedited 72-hour review when the Appeal request is made.

2) If the Contractor decides, based on medical criteria, that the Enrollee's situation is time-sensitive or if any physician makes the request for the Enrollee or calls or writes in support of the request for an expedited review, the Contractor must issue a decision as expeditiously as the Enrollee's health requires, but no later than 72 hours after receiving the request. The Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing. The Contractor may extend this time frame by up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension

of time benefits the Enrollee. The Contractor must make a decision as expeditiously as the Enrollee's health requires, but no later than the end of any extension period.

3) If the Contractor determines not to give the Enrollee an expedited Appeal, the Contractor must give the Enrollee prompt verbal notice followed by written confirmation within two calendar days that the Appeal will be decided within the time frame for a standard Appeal (30 calendar days).

4) If, on expedited Appeal, the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the Contractor's receipt of the Appeal (or no later than upon expiration of an extension discussed above).

5) The Contractor must ensure that punitive action is not taken against a Provider who either requests an expedited appeal or supports an Enrollee's appeal.

C. External Appeals

1. The CMS Independent Review Entity

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

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

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

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

d. If the CMS Independent Review Entity decides in the Enrollee's favor, the Contractor must authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision.

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

2. MassHealth Board of Hearings

At the point of receiving written notice of the Contractor's decision to deny, terminate, suspend, or reduce services, the Enrollee may, in addition to an internal Appeal, also request an external review by the MassHealth Board of Hearings (BOH). The BOH will render a final decision within the time limits specified at 130 CMR 610.015(D). Pursuant to 130 CMR 610.016, if an Enrollee elects a Provider to be his or her Appeal Representative, the Provider may request a BOH review of the Contractor's decision to deny, terminate, suspend, or reduce services.

a. Whenever the Contractor sends notification to an Enrollee of its service decision, the Contractor must include information on filing a BOH Appeal. The form and content of the notification used by the Contractor must be approved in advance by EOHHS and CMS.

b. The Enrollee must submit any request for a BOH Appeal, in writing, no later than 30 calendar days from the date of mailing of the Contractor's service decision.

c. Whenever an Enrollee submits a written request for a BOH Appeal within ten calendar days of the date of mailing of the Contractor's internal Appeal decision, the Contractor is responsible for the continued authorization or provision of any ongoing service in dispute during the pendency of a BOH Appeal.

d. If the BOH decides in the Enrollee's favor, the Contractor must authorize or provide the service in dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice of the BOH decision.

e. If the Contractor or the Enrollee disagrees with the BOH decision, there are further levels of Appeal available, including judicial review of the

decision under M.G.L. c. 30A. The Contractor must comply with any final decision upon judicial review.

f. The Contractor must designate an Appeal Coordinator to act as a liaison between the Contractor and BOH.

D. Hospital Discharge Appeals

1. When an Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation called a Notice of Discharge and Medicare Appeal Rights (NODMAR).
2. The Enrollee has the right to request a review by a QIO of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.
3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.
4. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.
5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar following the day the QIO notifies the Enrollee of its decision.
6. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

Section 2.10 Quality Management

The Contractor must operate an ongoing quality management program which includes quality assessment and performance improvement, in accordance with federal and State requirements. The Contractor must also participate in annual external quality reviews conducted by the External Quality Review Organization.

A. Annual Performance Improvement Projects

1. The Contractor must annually develop at least two specific Performance Improvement Projects in the Primary Care, long term care, or behavioral health areas. The Contractor must provide documentation on each project, describing:

    a. The objective;

    b. The rationale;

    c. How performance will be measured;

    d. The target population;

    e. The method of evaluating performance;

    f. How findings will be documented; and

    g. How recommendations will be development and implemented.

2. Annually on the anniversary of the start date of the Contract, the Contractor must provide EOHHS with reports on progress toward reaching established Quality Management Goals.

B. Continuous Quality Improvement

All clinical and nonclinical aspects of Contractor management must be based on principles of Continuous Quality Improvement (CQI). The quality management program must:

1. Recognize that opportunities for improvement are unlimited;
2. Be data driven;
3. Rely heavily on Enrollee input;
4. Rely heavily on input from all employees of the Contractor and its Subcontractors; and
5. Require measurement of effectiveness, continuing development, and implementation of improvements as appropriate.

C. Quality Management Resources

The Contractor must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. The following must be available:

1. Quality Management Director

   An identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Geriatric Model of Care.

2. Medical Director

   A medical director licensed by the Massachusetts Board of Registration in Medicine with geriatric expertise and experience in community and institutional long term care, who will be responsible for establishing medical protocols and practice guidelines to support the program initiatives in **Subsection 2.10(D)** below.

3. Geriatrician

   A qualified geriatrician, licensed by the Massachusetts Board of Registration in Medicine and further certified in Geriatric Medicine, who will be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support a geriatric model of practice.

4. Behavioral Health Clinician

   A qualified behavioral health clinician, with expertise in geriatric service, who will be responsible for establishing behavioral health protocols and providing specialized support to PCPs and PCTs.

D. Program Initiatives

1. Initiative to Reduce Preventable Hospital Admissions

   The Contractor must have and comply with written protocols to minimize unnecessary or inappropriate hospital admissions and a reporting system to record all preventable hospital admissions (see **Subsection 2.14(F)(1)).** The protocols must include at least the following:

   a. Monitoring and risk-assessment mechanisms, which are operative on a continuous basis, to identify Enrollees at-risk of hospitalization for at least the following conditions or profiles: pneumonia, dehydration, injuries from falls, skin breakdown, loss of informal caregiver, and history of noncompliance with treatment programs;

   b. Processes that link the Initial and Ongoing Assessments to the timely provision of appropriate preventive care and other treatment interventions to at-risk Enrollees. Such processes must emphasize continuity of care and coordination of services and must be in accordance with accepted clinical practice. The Contractor must perform outcome analyses to evaluate the effectiveness of the protocols; and

   c. Formal linkages among the PCP, PCT, and Providers (specialty, long term care, and behavioral health) through the Centralized Enrollee Record and other mechanisms, that must be used to provide timely information to the Contractor's Provider Network, in order to implement early interventions for Enrollees and prevent hospitalizations.

2. Discharge Planning Initiative

   The Contractor must have and comply with written protocols and a reporting system to record discharge activities (see **Subsection 2.14(F)(3)**) to ensure that Enrollees who are admitted to an institution receive the following:

   a. Interdisciplinary Discharge Planning and implementation processes that begin at the point of admission to the hospital or nursing facility;

   b. Involvement of the GSSC, the Providers of home- and community-based services, the Enrollee, and the Enrollee's designated representative, if any, in determining which discharge setting is appropriate; and

   c. Care planning and arranging for services that will be needed upon discharge.

3. Preventive Immunization

The Contractor must have and comply with written protocols to provide pneumococcal vaccine and timely annual influenza immunizations, as recommended by the Centers for Disease Control (CDC), and a reporting system to record all immunizations given (see **Subsection 2.14(A)(4)(a)**). The protocols must include the following components:

a. Development and distribution of Contractor and PCP/PCT practice guidelines and measurement of PCP/PCT compliance with the guidelines;

b. Educational Outreach to Enrollees and caregivers about appropriate preventive immunization schedules; and

c. Prompt access to immunizations for ambulatory, homebound, and institutionalized Enrollees.

4. Screening for Early Identification of Cancer

The Contractor must have and comply with written protocols to provide cancer-screening services, and the provision of appropriate follow-up services. The Contractor must develop a reporting system to record all tests given, positive findings, and actions taken to provide appropriate follow-up care (see **Subsection 2.14(A)(3)**). The protocols must include the following components:

a. Written practice guidelines developed in accordance with accepted clinical practice, provided to all PCP/PCTs, with compliance measured at least annually;

b. Education Outreach to both Enrollees and caregivers about preventive cancer-screening services;

c. Fecal occult-blood test annually; and

d. Mammography services: annually for women aged 65-69 and as medically appropriate for women aged 70-79.

5. Disease Management

The Contractor must have and comply with written protocols to manage the care for Enrollees identified with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and depression and a reporting system that produces clinical indicator data as required in **Subsection 2.14(A)(2)&(4).** The protocols must include the following:

a. Written practice guidelines, in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards;

b. Measurement and distribution of reports relating to Contractor and PCP/PCT compliance with practice guidelines;

c. Educational programming for Enrollees and caregivers that emphasizes self-care and maximum independence;

d. Formal educational processes for clinical Providers in the best practices of managing the disease; and

e. Evaluation of effectiveness of each program by measuring outcomes of care.

6. Management of Dementia

The Contractor must have and comply with written protocols to manage the care for Enrollees identified with dementia and a reporting system that produces clinical indicator data as required in **Subsection 2.14(A)(4)(b)(2).** The protocols must include the following:

a. Written practice guidelines in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards, with evaluation of the effectiveness of these protocols on outcomes of care;

b. Measurement and distribution of reports relating to compliance with practice guidelines;

c. Educational programming for significant caregivers that emphasizes community-based care and support systems for caregivers; and

d. Formal educational process for clinical Providers in the best practices of managing dementia.

7. Appropriate Nursing Facility Institutionalization

The Contractor must have and comply with written protocols for nursing facility admissions and report institutional utilization data as required in **Subsection 2.14(F).** The protocols must include the following activities:

a. Identify medical conditions and patient profiles that differentiate between Enrollees at risk of being institutionalized and those who require institutional care;

b. Develop monitoring and risk-assessment mechanisms that assist the PCP or PCT to identify Enrollees at risk of institutionalization;

c. Implement processes that link Initial and Ongoing Assessments to the timely provision of appropriate preventive care and treatment interventions to at-risk Enrollees. Such protocols must emphasize

continuity of care and coordination of services. The protocols must be based upon an evaluation of the outcomes and costs of care;

d. Implement processes to ensure the timely provision of nursing facility services when necessary;

e. Identify and formalize the linkages present between the PCPs, PCTs, and the long term care Providers of home- and community-based services, and how these linkages encourage and support maintaining Enrollees in their communities as long as appropriate; and

f. For individuals who can safely and adequately be cared for in the community, implement a Discharge Planning program that begins at the point of admission to any institution, to ensure the earliest appropriate discharge to community long term care.

8. Alcohol Abuse Prevention and Treatment Initiative

The Contractor must have and comply with written protocols to prevent, identify, and treat alcohol abuse and a reporting system that produces utilization data**.** Protocols must include the following:

a. Written practice guidelines, in accordance with accepted clinical guidelines, to treat alcohol abuse and evaluate the effectiveness of the treatment;

b. Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs;

c. Procedures for identifying Enrollees who are currently abusing alcohol or at risk for abusing alcohol; and

d. Documentation of coordination between the PCP or PCT and the behavioral health Provider.

9. Abuse and Neglect Identification Initiative

The Contractor is a mandated reporter of elder abuse under State law and must have and comply with written protocols to prevent and treat abuse and neglect of Enrollees and report incidents and actions taken. Protocols must include the following:

a. Diagnostic tools, in accordance with accepted clinical practice, for identifying Enrollees who are experiencing, or who are at risk of, abuse and neglect;

b. Written practice guidelines to treat abuse and neglect of Enrollees and evaluate effectiveness of interventions;

c. Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs; and

d. Documentation of coordination between the PCP or PCT and protective service Providers.

E. Assessment of New Medical Technology

The Contractor must maintain policies and procedures to evaluate the use of new medical technologies or new applications of established technologies including medical procedures, drugs, and devices specifically appropriate and effective for the geriatric population. The criteria and evaluation methods used in this process must be based on scientific evidence. Enrollee rights must be protected in accordance with **Appendix B**.

F. Enrollee Survey

The Contractor must administer an annual survey to all Enrollees and report the results to EOHHS on the anniversary of the start date of the Contract. Quality Management projects based on the findings must be developed and reported to EOHHS. As part of its measurement, the Contractor must conduct one survey or focus group with each of the following groups:

1. Non-English speaking Enrollees to assess their experience with the Contractor's ability to accommodate their needs;
2. Persons with physical disabilities to assess their experience with the Contractor's ability to meet their needs;
3. Enrollees from a minority ethnic group served by the Contractor to assess their experience with the Contractor's ability to provide culturally sensitive care and support to family members and care givers of Enrollees; and
4. Family members and significant caregivers of Enrollees to assess the Contractor's ability to support family members and significant others.

G. Health Promotion and Wellness Activities Performance

At a minimum, the Contractor must conduct an evaluation of the effectiveness of health promotion and wellness activities for Enrollees on each anniversary of the start date of the Contract, specifying the costs, benefits, and lessons learned. The Contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for Providers.

H. Ethics Committee

The Contractor must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including end-of-life issues and advance directives.

I. Serious Reportable Events

The Contractor shall cooperate with EOHHS in developing and implementing a process for ensuring non-payment for services constituting or resulting from so-called serious reportable events, as defined by the National Quality Forum.

Section 2.11 Outreach Standards

A. General Outreach Requirements

The Contractor shall:

1. Submit to EOHHS and CMS an annual comprehensive Outreach plan including proposed approaches to groups and individuals representing the cultural diversity of the Contractor's Service Area;
2. Obtain EOHHS and CMS approval of the Outreach plan and materials, before conducting any Outreach activities or distributing such materials;
3. Ensure that Outreach materials accurately reflect the Contractor's Provider Network and services offered and do not include false, misleading, or inaccurate information;
4. Refer Enrollees and Potential Enrollees who inquire about MassHealth eligibility or enrollment to EOHHS;
5. Make available to EOHHS and CMS, upon request, current schedules of all activities initiated or promoted by the Contractor to provide information or to encourage enrollment; and
6. Convene all promotional events at sites within the Contractor's Service Area that are physically accessible to all Consumers (for example, to those in wheelchairs and those using public transportation).

B. Requirements for Outreach and Enrollee Materials

The Contractor must:

1. Submit to EOHHS and CMS all forms of all Outreach and Enrollee materials, including non-English Outreach materials along with an English translation, an attestation from a certified translation agency, and a signature of the SCO Director, for review and approval before use or distribution. EOHHS and CMS must also approve any changes or updates to Outreach materials before use or distribution. Such materials include, but are not limited to:
    a. Outreach and education materials;
    b. Orientation materials;
    c. Enrollment and disenrollment materials;
    d. Benefit coverage information; and
    e. Operational letters for enrollment, disenrollment, claims, service denials, Complaints, Appeals, and Provider terminations.

2. Ensure that all information provided to Enrollees and Potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

    a. In large print (at least 12 point), including any footnotes and subscript annotations;

    b. Available in the Prevalent Languages used in the Service Area;

    c. Distributed throughout the entire Service Area;

    d. Written with sensitivity to literacy level and culture; and

    e. Available in written or oral format, according to the needs of Enrollees and Potential Enrollees, including oral interpretation services in non-English languages, audiotape, and other alternative media, as requested;

3. Ensure that all pre-enrollment and disenrollment materials include a statement that the Contractor's plan is a voluntary MassHealth benefit in association with EOHHS and CMS;

4. Have the following information available upon the request of an Enrollee or Potential Enrollee:

    a. A clear, comprehensive description of the Contractor's plan including all enrollment requirements;

    b. Detailed information about the Covered Services;

    c. A description of the options Enrollees and Potential Enrollees have to enroll, disenroll, and transfer on a monthly basis;

    d. A directory of all Providers in the Contractor's Provider Network;

    e. Information on the Enrollee's right to file a Complaint or Appeal; and

    f. Information on the process of accessing primary and specialty care, including Urgent Care and Emergency Conditions.

C. Optional Outreach Activities

The Contractor may:

1. Post written Outreach and promotional materials approved by CMS and EOHHS at Contractor Provider Network sites and other sites throughout the Service Area of the Contractor;
2. Access television, radio, and printed media, including free newspapers, for the purpose of Outreach or promotion in accordance with the requirements set forth in this Contract. All text, scripts, and materials developed by the Contractor for this purpose require review and approval by CMS and EOHHS before use;
3. Distribute approved Outreach and promotional materials by mail to Potential Enrollees throughout the Contractor's Service Area;
4. Provide nonfinancial promotional items only if they are offered to everyone who attends the event, regardless of whether or not they enroll with the Contractor, and only if the items are of a retail value of $10.00 or less; and
5. Conduct nursing facility visits and home visits for interested seniors only if the Contractor has documented a request to visit by a senior, a caregiver, or a responsible party.

D. Prohibited Outreach Activities

The Contract may not:

1. Offer financial or other incentives to induce Consumers to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor; or
2. Directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts.

Section 2.12 Financial Requirements

A. Financial Viability

1. Minimum Net Worth

The Contractor must demonstrate and maintain minimum net worth as specified below. For the purposes of this Contract, minimum net worth is defined as assets minus liabilities.

a. Throughout the term of this Contract, the Contractor must maintain a minimum net worth of $1,000,000, subject to the following conditions:

1) A minimum of $500,000 of this requirement must be in cash;

2) The Contractor may include 100% of the book value (the depreciated value according to generally accepted accounting principles (GAAP)) of tangible health care delivery assets carried on its balance sheet;

3) If at least $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 20% of the minimum net worth required will be allowed; and

4) If less than $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 10% of the minimum net worth required will be allowed.

2. Working Capital Requirements

The Contractor must demonstrate and maintain working capital as specified below. For the purposes of this Contract, working capital is defined as current assets minus current liabilities. Throughout the terms of this Contract, the Contractor must maintain a positive working capital, subject to the following conditions:

a. If a Contractor's working capital falls below zero, the Contractor must submit a written plan to reestablish a positive working capital balance for approval by EOHHS.

b. EOHHS may take any action they deem appropriate, including termination of the Contract, if the Contractor:

1) Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time;

2) Violates a corrective plan approved by EOHHS; or

3) EOHHS determine that negative working capital cannot be corrected within a reasonable time.

B. Financial Stability

1. Financial Stability Plan

a. Throughout the term of this Contract, the Contractor must:

1) Remain financially stable;

2) Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

a) Provide to Enrollees all Covered Services required by this Contract for a period of at least 45 calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

b) Continue to provide all such services to Enrollees who are receiving inpatient services at the date of insolvency until the date of their discharge or written approval to cease providing such services is received from EOHHS, whichever comes sooner; and

c) Guarantee that Enrollees and EOHHS do not incur liability for payment of any expense that is the legal obligation of the Contractor, any of its Subcontractors, or other entities that have provided services to Enrollees at the direction of the Contractor or its Subcontractors;

3) Immediately notify EOHHS when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any Subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency; and

4) Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any Provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.

2. Insolvency Reserve

a. The Insolvency Reserve shall be defined as the funding resources available to meet costs of providing services to Enrollees for a period of 45 days in the event that the Contractor is determined insolvent.

b. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.

c. The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor's estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.

d. Within 30 calendar days of receipt of the Insolvency Reserve calculation, the Contractor must submit to EOHHS written documentation of its ability to satisfy EOHHS' Insolvency Reserve Requirement. The documentation must be signed and certified by the Contractor's chief financial officer.

e. The Contractor may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; net worth of the Contractor (exclusive of any restricted cash reserves); performance guarantee as specified in **Section 2.12(B)(3)**; insolvency insurance; irrevocable letter of credit; and a formal written guarantee from the Contractor's parent organization.

3. Performance Guarantees and Additional Security

Throughout the term of this Contract, the Contractor must provide EOHHS with performance guarantees that are subject to prior review and approval from EOHHS. Performance guarantees must include:

a. A promissory note from the Contractor's parent(s) or a performance bond from an independent agent in the amount of $1,000,000 to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's impending or actual insolvency; and

b. A promissory note from the Contractor's parent(s) or a performance bond from an independent agent in the amount of $400,000 to guarantee performance of the Contractor's obligations to perform activities related to the administration of the Contract in the event of the Contractor's impending or actual insolvency.

C. Medical Loss Ratios

At the end of each Contract Year, the Contractor shall provide to EOHHS an audited statement of its medical loss ratio for the past year. Beginning after the fourth full year of operation as a SCO, the Contractor shall conform on an annual basis to any minimum medical loss ratio as established by EOHHS. Beginning after the fourth full year of operation as a SCO, if the Contractor's audited medical loss ratio is below a minimum level as established by EOHHS, the Contractor shall provide additional benefits or services to its Enrollees in the following Contract Year in an amount that would raise its medical loss ratio to the minimum level established by EOHHS, and shall submit a plan to EOHHS detailing how such benefits or services shall be provided to its Enrollees.

D. Other Financial Requirements

1. Auditing and Financial Changes

The Contractor must:

a. Ensure that an independent financial audit of the Contractor is performed annually. This audit must comply with the following requirements:

1) Provide EOHHS with the Contractor's most recent audited financial statements; and

2) Provide an independent auditor's report on the processing of the transactions using the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards SAS 70 protocol and Chapter 647 of the Acts of 1989 (also known as the Internal Control Law);

b. Submit on an annual basis after each annual audit a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed;

c. Utilize a methodology approved by EOHHS to estimate incurred but not reported (IBNR) claims adjustments;

d. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency;

e. Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract;

f. Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract; and

g. Refrain from investing funds in, or loaning funds to, any organization in which a director or principal officer of the Contractor has an interest.

2. Risk Arrangements

The Contractor may maintain Provider risk arrangements. The Contractor must disclose these arrangements to EOHHS as follows.

a. The Contractor must provide a description of any changes in its risk arrangements with all members of its Provider Network, including but not limited to Primary Care, specialists, hospitals, nursing facilities, other long term care Providers, behavioral health Providers, and ancillary services.

b. Any incentive arrangements must not include any specific payment as an inducement to withhold, limit, or reduce services to Enrollees.

c. The Contractor must monitor such arrangements, in accordance with the standards of EOHHS and CMS for quality of care, to ensure that medically appropriate Covered Services are not withheld.

3. Right to Audit and Inspect Books

The Contractor must grant EOHHS the right to audit and inspect its books and records related to:

a. The Contractor's capacity to bear the risk of potential financial losses; and

b. Services performed or the determination of amounts payable under the Contract.

4. Other Information

The Contractor must provide EOHHS with any other information that EOHHS deems necessary to adequately monitor and evaluate the financial strength of the Contractor or that must be provided to EOHHS by law.

5. Reporting

To demonstrate that the Contractor has met the requirements of this **Subsection 2.12**, the Contractor must submit to EOHHS all required financial reports, as described in this **Subsection 2.12** and **Appendix D**, in accordance with specified timetables, definitions, formats, assumptions, and certifications as well as any ad hoc financial reports required by EOHHS.

6. Financial Responsibility for Post-Stabilization Services

The Contractor must pay for post-stabilization services in accordance with 42 CFR 438.114e and 42 CFR 422.113(C)(2) and (3).

Section 2.13 Data Submissions, Reporting Requirements, and Surveys

A. General Requirements for Data

The Contractor must provide and require its Subcontractors to provide:

1. All information EOHHS requires under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation; and
2. Any information EOHHS requires to comply with all applicable federal or State laws and regulations.

B. General Reporting Requirements

The Contractor must:

1. Be responsible for all administrative costs associated with the development, production, mailing, and delivery of all reports required under the Contract;
2. Submit all required reports in accordance with the specifications, templates, and time frames described in this Contract and **Appendix D**, unless otherwise directed or agreed to by EOHHS. The Contractor must submit all proposed modifications, revisions, or enhancements to any reports to EOHHS for approval prior to making such changes;
3. If EOHHS does not approve any report the Contractor submits, correct or modify the report as directed by EOHHS and resubmit it to EOHHS for final acceptance and approval within agreed-upon time frames;
4. At request of EOHHS provide additional ad hoc or periodic reports or analyses of data related to the Contract, according to a schedule and format specified or agreed to by EOHHS;
5. Have the capacity to display data graphically, in tables, and in charts, as directed by EOHHS;
6. Apply generally accepted principles of statistical analysis and tests for statistical significance, as appropriate, to data contained in reports;
7. Ensure that all reports are identified with a cover page that includes at least the following information:
    a. Title of the report;
    b. Production date of the report;
    c. Contact person for questions regarding the report;
    d. Data sources for the report;
    e. Reporting interval;

f. Date range covered by the report; and

g. Methodology employed to develop the information for the report;

8. Provide with each report a narrative summary of the findings contained in the report, analyses, and actions taken or planned next steps related to those findings;

9. Submit one printed original and two printed copies of each report and, also make each report available electronically in a format and media compatible with EOHHS software and hardware requirements. The original and printed copies must:

   a. Be in a loose-leaf binder;

   b. Be clearly labeled with the titles of the reports it contains; and

   c. Have clear separations between reports when more than one report is contained in one binder;

10. Provide EOHHS with reports and necessary data to meet all applicable federal and State reporting requirements within the legally required time frames; and

11. Provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to "annual" or "year-to-date" reports or data refer to the Contract Year, unless otherwise specified. EOHHS may at its sole discretion assess financial penalties as described in **Subsection 5.5(P)** for failure to perform any reporting requirements.

   a. Incident Reports – deliver incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the next business day after the Contractor receives incident notification, in accordance with the established protocol.

   b. Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported, if the 20th of the month falls on a non-business day, the next business day; except for October, January, April, and July, when monthly reports may be submitted with quarterly reports.

   c. Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, that is, October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Quarterly reports due January 30 and July 30 may be submitted with semiannual reports.

   d. Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, that is, January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Semiannual reports due July 30 may be submitted with annual reports.

e. Annual Reports – no later than the 45th day after the end of the Contract Year, or, if the 45th day falls on a non-business day, the next business day.

f. One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by EOHHS.

C. Participation in Surveys

The Contractor agrees to participate in surveys required by EOHHS and to submit all information requested by EOHHS to administer and evaluate the program. This survey information regarding the Contractor must include, but not be limited to:

1. Plan quality and performance indicators, including:

   a. Information on Enrollee satisfaction;

   b. The availability, accessibility, and acceptability of services; and

   c. Information on health outcomes and other performance measures.

2. Information about Enrollee Appeals and their disposition; and
3. Information regarding formal actions, reviews, findings, or other similar actions by any governmental body, or any certifying or accrediting organization.

D. Certification Requirements

1. In accordance with 42 CFR 438.600 *et seq.*, the Contractor's Chief Executive or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit a certification to EOHHS, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of his or her knowledge, information and belief, after reasonable inquiry:

   a. Data on which payments to the Contractor are based;

   b. All enrollment information, and measurement data; and

   c. Data and other information required by EOHHS including, but not limited to, reports and data described in this Contract.

2. The Contractor must submit the certification concurrently with the certified data.

Section 2.14 Required Program Reports

A. Clinical Indicator Data

1. The Contractor must report clinical indicator data in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA), to the extent they are relevant to the SCO population.
2. For calendar year 2009, the following HEDIS measures must be collected according to HEDIS specifications, and reported to EOHHS on the same time schedule required by CMS.
    a. Glaucoma Screening for Older Adults;
    b. Use of Spirometry Testing in the Assessment and Diagnosis of COPD;
    c. Persistence of Beta Blocker Treatment after a Heart Attack;
    d. Osteoporosis Management in Older Women;
    e. Antidepressant Medication Management;
    f. Follow-up After Hospitalization for Mental Illness;
    g. Annual Monitoring for Patients on Persistent Medication;
    h. Potentially Harmful Drug-Disease Interactions;
    i. Use of High-Risk Medication in the Elderly; and
    j. Board Certification.
3. Required HEDIS SNP Measure for 2012 and Beyond
    a. The Contractor must comply with the HEDIS reporting requirements as they are developed and approved by NCQA and CMS.
    b. For 2010, the Contractor must report the following to EOHHS using NCQA specifications and the CMS time frames:
        1) Colorectal Cancer Screening;
        2) Pharmacotherapy of COPD Exacerbation; and
        3) Controlling High Blood Pressure.
4. The following clinical indicator data, which relate to the program initiatives in **Subsection 2.10(D)**, must be reported annually and submitted to EOHHS no later

than the 120th day after the end of the calendar year, or if the 120th day falls on a non-business day, the next business day. The technical definitions of such indicators and the reporting format will be provided jointly by CMS and EOHHS.

a. Preventive Medicine

1) Influenza immunization rates: the percentage of Enrollees who have received an influenza vaccination in the past year.

2) Pneumococcal vaccination rate: the percentage of Enrollees who have received the pneumococcal vaccination at any time.

3) Fecal occult blood teting: percentage of Enrollees who received a fecal occult blood test during the past year.

4) Mammography screening: percentage of female Enrollees age 65-69 who received a mammogram during the past year, and percentage of female Enrollees age 70-79 who received a mammogram during the past year.

5) Eye examination every two years: percentage of Enrollees who received vision screening in the past two years.

6) Hearing examination every two years: percentage of Enrollees who received a hearing screening in the past two years.

7) Screening for alcohol abuse: percentage of Enrollees reporting alcohol utilization in the CAGE risk areas, and percentage of those referred for counseling.

b. Acute and Chronic Disease

1) Enrollees Diagnosed with Diabetics Mellitus (DM)

a) The number of Enrollees diagnosed with DM;

b) The percentage on insulin;

c) The percentage who received a glycosylated hemoglobin test in the past year;

d) The percentage who received a blood test for cholesterol or LDL in the past year; and

e) The percentage who received an opthamologic dilated fundoscopic examination in the past year.

2) Enrollees Diagnosed with Dementia

a) The number of Enrollees diagnosed with dementia;

b) The percentage who are receiving geriatric support services;

c) The percentage with severe behavioral symptoms (such as wandering or assaultiveness);

d) The percentage residing in nursing facilities; and

e) The percentage receiving community long term care services.

3) Enrollees Diagnosed with Chronic Obstructive Pulmonary Disease (COPD)

a) Number of Enrollees diagnosed with COPD

b) Percentage who received pneumococcal vaccine at any time.

c) Percentage who received influenza immunization within the past year.

d) Number hospitalized for COPD and average lengths of stay.

e) Of those hospitalized, percentage who received corticosteroid treatment prior to admission.

f) COPD readmission rate (the number of Enrollees admitted more than once for COPD during the past year);

g) COPD readmission rate ratio (the ratio of Enrollees admitted more than once for COPD compared to Enrollees admitted only once for COPD).

4) Enrollees Diagnosed with Congestive Heart Failure (CHF)

a) Number of Enrollees diagnosed with CHF.

b) Number of Enrollees hospitalized for CHF and average lengths of stay during the past year.

c) Percentage for whom angiotensin converting enzyme (ace) inhibitors were prescribed.

d) CHF readmission rate (the number of Enrollees admitted more than once for CHF during the past year).

e) CHF readmission rate ratio (the ratio of Enrollees admitted more than once for CHF compared to Enrollees admitted only once).

5) Enrollees Diagnosed with Depression

a) Number of Enrollees diagnosed with depression.

b) Percentage receiving antidepressants.

c) Percentage with inpatient psychiatric admissions with average length of stay during the past year.

d) Percentage with psychiatric readmissions within 30 calendar days.

e) Percentage of outpatient visits with a mental health provider.

f) Percentage of these Enrollees who received an ambulatory follow-up visit within one month of hospital discharge.

B. Encounter Reporting

The Contractor must meet any diagnosis or encounter reporting requirements required by federal law or that may be determined necessary by EOHHS.

C. Enrollee Orientation Performance

The Contractor must evaluate the effectiveness of Enrollee orientation activities and report the results to EOHHS on each anniversary of the start date of the Contract, specifying the costs and benefits of implementation and the lessons learned. The Contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for Providers and administrative staff.

D. Complaints and Appeals

1. On a monthly basis, the Contractor must report the number and types of Complaints filed by Enrollees and received by the Contractor, specifying how and in what time frames they were resolved (see Subsections 2.8 and 2.9). The Contractor must cooperate with EOHHS to implement improvements based on the findings of these reports.
2. The Contractor must report the number, types, and resolutions of Appeals filed, including, for external Appeals, whether the external review was by the CMS Independent Review Entity or by the MassHealth Board of Hearings.

E. Disenrollment Rate

The Contractor must report annually voluntary disenrollment rates and reasons (see **Subsection 2.3(E)(5)**). The Contractor must track such information and develop interventions to address opportunities for improvement identified through the analysis of voluntary disenrollments.

F. Institutional Utilization Data

The Contractor must report institutional utilization data annually for Enrollees, including, but not limited to the following, by gender categories and age groups as defined by and in the format provided by EOHHS.

1. Rate of Preventable Hospital Admissions (for example, Pneumonia, COPD, CHF, Dehydration and Urinary Tract Infection)

    a. Admissions per 1,000 Enrollees for each condition and in total;

    b. Average length of stay;

    c. Readmission rate within seven calendar days; and

    d. Readmission rate within 30 calendar days.

2. Rate of Nursing Facility Admissions

    a. Admissions per 1,000 Enrollees for short-term rehabilitation or recovery (90 calendar days or less);

    b. Admissions per 1,000 Enrollees for long-term or permanent placement; and

    c. Readmission rate to nursing facilities within 60 calendar days of nursing facility discharge.

3. Enrollees Discharged from a Nursing Facility

    The percentage of Enrollees with the following length of stay at date of discharge and the disposition after discharge, whether home, another institution, or death:

    a. Less than 30 calendar days;

    b. 30 - 90 calendar days;

    c. 90 calendar days to one year;

    d. One year to three years; and

e. Longer than three years.

4. Enrollees Residing in Nursing Facilities

Until such time as EOHHS can access MDS 3.0 nursing facility data at the level of detail below, the Contractor must report the following:

a. The number of Enrollees with diagnoses of dementia and the percentages of those with the following lengths of stay:

1) Less than 30 calendar days;

2) 30-90 calendar days;

3) 90 calendar days to one year;

4) One year to three years; and

5) Longer than three years.

b. The number of Enrollees with urinary incontinence and the number of Enrollees with urinary catheters, as well as the percentages of those with the following lengths of stay:

1) Less than 30 calendar days;

2) 30-90 calendar days;

3) 90 calendar days to one year;

4) One year to three years; and

5) Longer than three years.

5. Rate of Acute Hospital Admissions

a. Admissions per 1,000 Enrollees;

b. Average length of stay;

c. Readmission rate within seven calendar days; and

d. Readmission rate within 30 calendar days.

6. Rate of Chronic Hospital Admission

   a. Admissions per 1,000 Enrollees for short-term rehabilitation or recovery (90 calendar days or less) with average length of stay;

   b. Admissions per 1,000 Enrollees for long-term or permanent placement with average length of stay; and

   c. Readmission rate to chronic hospitals within 60 calendar days of chronic hospital discharge.

G. Community Health Service Utilization

The Contractor must report community health service utilization data for Enrollees, including number of units and units per 1,000 Enrollees by age group and gender categories. Units means days unless otherwise noted. The data must be reported in the following summary categories.

1. Adult day health;
2. Home health (units = visits);
3. Group adult foster care;
4. Family adult foster care;
5. Hospice;
6. Homemaker, chore, respite and other non-medical residential support services (units = hours); and
7. Personal care attendant (units = hours).

H. Enrollees Medically Eligible for Nursing Facility Services

The Contractor must report quarterly on Enrollees who are medically eligible for nursing facility services, by age group and gender, in the following categories.

1. Number in Nursing Facilities at the End of the Quarter

   a. Total days hospitalized; and

   b. Total days in a nursing facility.

2. Number Living in the Community at the End of the Quarter

   a. Total days hospitalized; and

   b. Total days in a nursing facility.

3. Number who Died during the Quarter

   a. Those who died in the nursing facility;

   b. Thos who died in the hospital; and

   c. Those who died in the community.

I. Functional Data

The Contractor must report the need for assistance with Activities of Daily Living (ADLs) annually for all Enrollees by age and gender. This data will be collected in accordance with the Mimimum Data Set (MDS), and will include the number of Enrollees per 1,000 needing limited assistance and number of Enrollees per 1,000 needing extensive or total assistance with:

1. Mobility;
2. Transfer;
3. Dressing;
4. Eating;
5. Toilet use;
6. Personal hygiene; and
7. Bathing.

J. Mortality Data

The Contractor must report mortality data annually, by age and gender, in the following categories:

1. The number of Enrollees who died during the past year;
2. Percentage who died in hospitals;
3. Percentage who died in nursing facilities;
4. Percentage who died in non-institutional settings; and
5. Cause of death.

K. Medications

The Contractor must report Enrollee-specific prescription data through MDS 2.0 for nursing residents and the MDS-HC for home care.

Section 2.15 Information Management and Information Systems

A. General

The Contractor shall:

1. Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract;
2. Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS; and
3. Cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS.

B. Design Requirements

1. The Contractor shall comply with EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.
2. The Contractor's Systems shall interface with EOHHS's legacy Medicaid Management Information System (MMIS) and NewMMIS, and the EOHHS Virtual Gateway.
3. The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files shall include, but are not limited to:

    a. Inbound Interfaces

        1) Daily inbound member enrollments and disenrollments;

        2) HIPAA 834 History Request File; and

        3) Monthly Managed Care Provider Directory.

    b. Outbound Interfaces

        1) HIPAA 834 Outbound Daily File;

        2) HIPAA 834 Outbound Full File;

        3) HIPAA 834 History Response; and

        4) HIPAA 820.

c. SCO Provider Directory Database

1) Provider types and specialties;

2) Working hours;

3) Languages spoken; and

4) Access for disabled Consumers.

4. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

5. The Contractor shall demonstrate controls to maintain information integrity.

6. The Contractor shall access the state's Virtual Gateway to enroll and disenroll members through Direct Data Entry (DDE) or through the HIPAA 834 transaction.

C. System Access Management and Information Accessibility Requirements

1. The Contractor shall make all Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.

2. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

D. System Security and Privacy Requirements

The Contractor shall implement administrative, physical and technical safeguards necessary to ensure the confidentiality, availability and integrity of all personally-identifiable data (which shall include, but not be limited to, "protected health information" as such term is defined under HIPAA), as well as any additional security measures required by other state or federal laws or regulations, at EOHHS's request.

SECTION 3. EOHHS RESPONSIBILITIES IN COORDINATION WITH CMS

Section 3.1 Contract Management

A. Administration

EOHHS will coordinate contract management with CMS and will:

1. Designate a Contract Management Team that will include, at least one contract officer from EOHHS and one representative from CMS, authorized and empowered to represent CMS and EOHHS about all aspects of the Contract. The CMS representative and the EOHHS representative will act as liaisons between the Contractor and CMS and EOHHS for the duration of the Contract. The Contract Management Team will:

    a. Monitor compliance with the terms of the Contract. EOHHS will be responsible for the day-to-day monitoring of the Contractor's performance and will periodically report to CMS and the Executive Office of Elder Affairs. CMS will communicate directly with the Contractor as necessary;

    b. Receive and respond to all inquiries and requests made by the Contractor under this Contract in a timely manner;

    c. Meet with the Contractor's Director on a periodic or as-needed basis, resolving issues that arise;

    d. Coordinate requests for assistance from the Contractor and assign staff with appropriate expertise to provide technical assistance to the Contractor;

    e. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor; and

    f. Inform the Contractor of any discretionary action by EOHHS or CMS under the provisions of the Contract;

2. Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;
3. Review, approve, and monitor the Contractor's Complaint and Appeals procedures;
4. Apply one or more of the sanctions provided in **Subsection 5.5(P)**, including termination of the Contract in accordance with **Subsection 5.7**, if CMS and EOHHS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

5. Conduct site visits of the Contractor annually, or as determined necessary to verify the accuracy of reported data; and

6. Coordinate the Contractor's external quality reviews conducted by the external quality review organization.

B. Performance Evaluation

EOHHS, in coordination with CMS will, at their discretion:

1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in **Subsections 2.13 and 2.14**, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. EOHHS will coordinate with CMS to provide the Contractor with the written results of these evaluations;

2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and

4. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

Section 3.2 Enrollment, Disenrollment, and Rating Category Determinations

EOHHS and CMS will maintain separate systems to provide:

A. Enrollment, disenrollment, and rating-category determinations;

B. Enrollment, disenrollment, rating-category determination information to the Contractor; and

C. Continuous verification of eligibility status.

Section 3.3 Outreach

EOHHS will coordinate with CMS to:

A. Monitor the Contractor's Outreach activities and distribution of related materials;

B. Coordinate Outreach monitoring activities, as described in **Subsection 2.11**;

C. Conduct an ongoing review of Outreach activities, including:

1. Approval of all Outreach materials, in all forms, prior to use;
2. Random onsite review of Outreach forums, products, and activities;
3. Random review of actual Outreach pieces as they are used in or by the media; and
4. For-cause review of materials and activities when Complaints are made by any source; and

D. If EOHHS or CMS find that the Contractor is violating these requirements, monitor the development and implementation of a corrective action plan.

SECTION 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.1 General Financial Provisions

A. Capitation Payments

EOHHS will make monthly capitation payments to the Contractor in accordance with the rates of payment and payment provisions set forth herein for all Covered Services actually and properly delivered to eligible Enrollees in accordance with and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive two monthly capitation payments for each Dual Eligible Enrollee: one amount from Medicare and a second amount from MassHealth. Medicare and MassHealth each produce different Rate Cells (RCs) according to the individual Enrollee's clinical and demographic status and setting of care.

For those Enrollees who are eligible for MassHealth only, the Contractor will receive one monthly capitation payment from MassHealth.

B. Modifications to Capitation Rates

EOHHS will notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates by RC. Updated MassHealth Capitation Rates will be established by amendment to this Contract.

Section 4.2 MassHealth Rate Cells (RCs)

MassHealth will pay the Contractor monthly capitation amounts for Enrollees according to the RCs in **Subsection 4.2(A)-(F)**.

MassHealth Capitation Rates for community-based Enrollees will vary according to two regions: Greater Boston and Outside Greater Boston. These regions are defined by the zip code of the Enrollee's residence. A table of cities and zip codes for the Greater Boston Region is attached as **Appendix F**.

	Community Settings of Care			**Institutional Settings of Care**		
	Other	**AD/CMI***	**NHC***	**Tier 1***	**Tier 2***	**Tier 3***
Dual Eligible, Greater Boston	RC 20	RC 22	RC 24	RC 26	RC 27	RC 28
Dual Eligible, Outside Greater Boston	RC 21	RC 23	RC 25	RC 26	RC 27	RC 28
MassHealth Only, Greater Boston	RC 30	RC 32	RC 34	RC 36	RC 37	RC 38
MassHealth Only, Outside Greater Boston	RC 31	RC 33	RC 35	RC 36	RC 37	RC 38

*AD/CMI is Alzheimer's/Dementia or Chronic Mental Illness. NHC is Nursing Home Certifiable. See **Subsections 4.2(D), (E) and (F)** below for a description of tier levels.

A. Community Other

If an Enrollee is a community resident, does not meet NHC criteria, and does not have a diagnosis of Alzheimer's disease, dementia, or chronic mental illness, the Enrollee will be classified as Community Other.

1. RC 20: Community Other, Dual Eligible, Greater Boston

   If the Community Other Enrollee is Dual Eligible and resides in Greater Boston, the Contractor will be paid a monthly RC 20 rate for every month in which the Enrollee remains in this RC.

2. RC 21: Community Other, Dual Eligible, Outside Greater Boston

   If the Community Other Enrollee is Dual Eligible and resides Outside Greater Boston, the Contractor will be paid a monthly RC 21 rate for every month in which the Enrollee remains in this RC.

3. RC 30: Community Other, Medicaid Only, Greater Boston

   If the Community Other Enrollee is Dual Eligible and resides in Greater Boston, the Contractor will be paid a monthly RC 30 rate for every month in which the Enrollee remains in this RC.

4. RC 31: Community Other, Medicaid Only, Outside Greater Boston

   If the Community Other Enrollee is Dual Eligible and resides Outside Greater Boston, the Contractor will be paid a monthly RC 31 rate for every month in which the Enrollee remains in this RC.

B. Community Alzheimer's Disease/Dementia or Chronic Mental Illness (AD/CMI)

If an Enrollee is a community resident, does not meet NHC criteria, and has a diagnosis of AD/CMI, the Enrollee will be classified as Community AD/CMI.

1. RC 22: Community AD/CMI, Dual Eligible, Greater Boston

   If the Community AD/CMI Enrollee is Dual Eligible and resides in Greater Boston, the Contractor will be paid a monthly RC 22 rate for every month in which the Enrollee remains in this RC.

2. RC 23: Community AD/CMI, Dual Eligible, Outside Greater Boston

   If the Community AD/CMI Enrollee is Dual Eligible and resides Outside Greater Boston, the Contractor will be paid a monthly RC 23 rate for every month in which the Enrollee remains in this RC.

3. RC 32: Community AD/CMI, MassHealth Only, Greater Boston

   If the Community AD/CMI Enrollee is MassHealth only and resides in Greater Boston, the Contractor will be paid a monthly RC 32 rate for every month in which the Enrollee remains in this RC.

4. RC 33: Community AD/CMI, MassHealth Only, Outside Greater Boston

   If the Community AD/CMI Enrollee is MassHealth only and resides Outside Greater Boston, the Contractor will be paid a monthly RC 33 rate for every month in which the Enrollee remains in this RC.

C. Nursing Home Certifiable (NHC)

If an Enrollee is a community resident, is limited in two or more activities of daily living (ADLs), and has a skilled nursing need three or more times per week, as recorded through the Minimum Data Set/Home Care (MDS/HC) form and approved by EOHHS, or if an Enrollee is in the first three months of a nursing facility stay, the Enrollee will be classified NHC.

1. RC 24: NHC, Dual Eligible, Greater Boston

   If the Enrollee is Dual Eligible and resides in Greater Boston, the Contractor will be paid a monthly RC 24 rate for every month in which the Enrollee remains in this RC.

2. RC 25: NHC, Dual Eligible, Outside Greater Boston

   If the Enrollee is Dual Eligible and resides Outside Greater Boston, the Contractor will be paid a monthly RC 25 rate for every month in which the Enrollee remains in this RC.

3. RC 34: NHC, MassHealth Only, Greater Boston

   If the Enrollee is MassHealth only and resides in Greater Boston, the Contractor will be paid a monthly RC 34 rate for every month in which the Enrollee remains in this RC.

4. RC 35: NHC, MassHealth Only, Outside Greater Boston

   If the Enrollee is MassHealth only and resides Outside Greater Boston, the Contractor will be paid a monthly RC 35 rate for every month in which the Enrollee remains in this RC.

D. Institutional Tier 1

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Categories (MMC) level H, J, or K, the Enrollee will be classified as Institutional Tier 1. The Contractor will be paid a monthly RC 26 rate for Dual Eligible Enrollees or a monthly RC 36 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

The Contractor will also be paid at the Institutional Tier 1 rate (RC 26 or RC 36) for those months which fall in the first three months after an Enrollee's discharge from a nursing facility to a community setting.

E. Institutional Tier 2

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Categories (MMC) level L, M, N, P, R, or S, the Enrollee will be classified as Institutional Tier 2. The Contractor will be paid a monthly RC 27 rate for Dual Eligible Enrollees or a monthly RC 37 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

The Contractor will also be reimbursed at the Institutional Tier 2 rate (RC 27 or RC 37) for nursing facility residents who have elected hospice and who have resided in a nursing facility for more than three months.

F. Institutional Tier 3

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Category (MMC) level T, the Enrollee will be classified as Institutional Tier 3. The Contractor will be paid a monthly RC 28 rate for Dual Eligible Enrollees or a monthly RC 38 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

Section 4.3 Medicare Payment

To obtain payment from Medicare, the Contractor shall comply with the Medicare-Advantage-Part D provisions.

Section 4.4 Payment Terms

EOHHS will make monthly, prospective capitation payments to the Contractor. The MassHealth capitation payment for each RC will be the product of the number of Enrollees in each category multiplied by the payment rate for that RC. Patient contribution to care amounts will be deducted from the total MassHealth monthly capitation payment amount, in accordance with **Subsection 4.4(B)**.

A. Timing of Capitation Payments

1. New Enrollments

   EOHHS will make capitation payments for Enrollees. Enrollments received and approved by EOHHS on or before the last business day of the month will be effective the first calendar day of the following month. EOHHS will make monthly capitation payments to the Contractor for the month beginning on the effective date of enrollment.

2. Disenrollments

   If a disenrollment form is signed by the Enrollee (or Enrollee's representative) and submitted to EOHHS on or before the last business day of the month, the disenrollment will be effective on the first calendar day of the following month. The final capitation payment made by EOHHS to the Contractor for this Enrollee will be for the month in which the disenrollment was submitted.

3. After an Enrollee's Death

   EOHHS' final capitation payment for an Enrollee who dies will be for the month in which the Enrollee died. The Contractor is not entitled to capitation payments for subsequent months.

B. Patient Contribution to Care Amounts

If, in the financial eligibility process conducted by EOHHS, an Enrollee residing in a nursing facility is determined to owe a monthly patient-paid amount, such amounts are the Enrollee's contribution to care. At the time of enrollment, and as adjusted thereafter, EOHHS will advise the Contractor of the amount of the Enrollee's contribution to care. When an Enrollee contribution to care is established, EOHHS will subtract that amount from the monthly capitation payment for that Enrollee. The Contractor is responsible for collecting this amount from the Enrollee subject to the Enrollee rights provisions of the Contractor's Evidence of Coverage (see **Appendix B**).

C. American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

1. The Contractor shall offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;
2. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to SCO Covered Services for Indian Enrollees;
3. The Contractor shall pay both network and non-network Indian Health Care Providers who provide SCO Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the SCO Covered Service provided by a non-Indian Health Care Provider;
4. The Contractor shall make prompt payment to Indian Health Care Providers; and
5. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider.

Section 4.5 MassHealth Transitions between Rate Cells

MassHealth Capitation Rates will be updated following a change in an Enrollee's status, based on the Minimum Data Set Forms (the MDS.20 and the MDS/HC) and the Status Change Form (SC-1) for Nursing Facility Residents, or any subsequent forms required by EOHHS. The MassHealth transition rules are as follows:

A. Institutional to Community RC

For a transition from an institutional RC (Tier 1, 2, or 3) into a community RC, the rate change will become effective on the first calendar day of the month following 90 calendar days after discharge.

B. Between Community RCs

For a transition between community RCs, if the MDS/HC form is received and approved on or before the last day of the month, the rate change will become effective on the first calendar day of the following month.

C. Between Institutional RCs

For a transition between institutional RCs, the rate change will become effective on the first calendar day of the month after the MDS 2.0 is received and approved by EOHHS.

D. Community to Institutional RC

For a transition from one of the community RCs into an institutional RC (Tier 1, 2, or 3), the rate will first change to NHC, if the Enrollee is not already assigned to that RC, on the first day of the month after the Enrollee becomes institutionalized. If the Enrollee has not been discharged after 90 calendar days, the rate will change to the appropriate institutional RC (Tier 1, 2, or 3) on the first day of the month following 90 calendar days at the NHC rate.

Section 4.6 Reconciliation

EOHHS will implement a process to reconcile enrollment and capitation payments for each Contractor that will take into consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or patient contribution amounts; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

A. MassHealth Capitation Reconciliation

EOHHS will:

1. Perform a quarterly reconciliation of the monthly capitation payments as described below:

    a. Calculate the correct Capitation Rate for each month per Enrollee by determining the Enrollee's appropriate RC and the appropriate patient contribution; and

    b. Reconcile the monthly Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate as calculated in **Subsection 4.6(A)(1)(a)** above; and

2. Remit to the Contractor the full amount of any underpayment it identifies pursuant to **Subsection 4.6(A)(1)**. The Contractor must remit to EOHHS the full amount of any overpayments identified by EOHHS pursuant to **Subsection 4.6(A)(1)**. Such payment shall be made through a check or other funds transfer method acceptable to EOHHS, or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.

B. Audits

EOHHS will conduct periodic audits to validate RC assignments. Audits may be conducted by a peer review organization or other entity assigned this responsibility by EOHHS.

Section 4.7 Federal Payment Approval

The federal government requires that states meet certain state plan requirements and certify to the federal government that MassHealth capitation payments do not exceed the cost of providing Covered Services on a fee-for-service basis to an actuarially equivalent population. If any portion of the MassHealth capitation payment methodology is not approved by CMS, any payment made by EOHHS in excess of the MassHealth payments resulting from the federally approved methodology will be deemed an overpayment. EOHHS may collect such overpayment through a deduction from future payments to the Contractor.

Section 4.8 Payment in Full

The Contractor must accept, as payment in full for all obligations under this Contract, the MassHealth Capitation Rates and the terms and conditions of payment set forth herein.

SECTION 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.1 Administration

A. Notification of Administrative Changes

The Contractor must notify EOHHS and CMS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify EOHHS and CMS in writing no later than 30 calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a Subcontractor pursuant to **Subsection 2.5(B)(3).** The Contractor must notify EOHHS and CMS in writing of all other changes no later than five business days prior to the effective date of such change.

B. Assignment

The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of EOHHS and CMS, which may be withheld for any reason or for no reason at all.

C. Independent Contractors

The Contractor, its employees, Subcontractors, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government, the Commonwealth of Massachusetts, EOHHS, or CMS.

D. Subrogation

Subject to EOHHS and CMS lien and third-party recovery rights, the Contractor must:

1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;
2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

    a. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

    b. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem

appropriate to protect its rights hereunder whether or not such notice is given.

E. Prohibited Affiliations

In accordance with 42 USC §1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

The Contractor warrants and represents that it will not, in accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, knowingly have an employment, consulting or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded, under federal or state law, regulation, executive order, or guidelines, from certain procurement and non-procurement activities. The Contractor further warrants and represents that no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer or partner of the Contractor.

The Contractor further warrants and represents that the Contractor does not meet any of the conditions set forth in 42 CFR 438.808(b).

F. Disclosure Requirements

The Contractor must disclose to EOHHS and CMS, information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 USC §1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act.

G. Physician Incentive Plans

1. The Contractor may, in its discretion, operate a physician incentive plan only if:

    a. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

    b. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

    c. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 CFR 417 are met.

2. The Contractor and its Subcontractors must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR 438.6(h). The Contractor must submit all information required to be disclosed to EOHHS and CMS in the manner and format specified by EOHHS and CMS, which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts and 42 CFR 422.208 and 42 CFR 422.210. The Contractor must provide information on its physician incentive plan to any Enrollee upon request. If the Contractor is required to conduct a beneficiary survey, survey results must be disclosed to EOHHS and to any Enrollee upon request.

3. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor's or its Subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 422 and 438; provided, however, that the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan; provided, further, that the Contractor shall not be liable if it can demonstrate, to the satisfaction of EOHHS and CMS, that it has made a good faith effort to comply with the cited requirements.

H. Physician Identifier

The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. §1320d-2(b). The Contractor must provide such unique identifier to EOHHS and CMS for each of its PCPs in the format and time frame established by EOHHS and CMS in consultation with the Contractor.

I. Timely Payments to Contracted Providers

The Contractor must make payment on a timely basis to Providers for SCO Covered Services furnished to Enrollees, in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. Unless otherwise provided for and mutually agreed to in an agreement between the Contractor and a Provider, the Contractor must ensure that 90% of payment claims from physicians, who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within 90 days of the date of receipt of the claim. The Contractor and its contracted Providers may by mutual agreement, in writing, establish an alternative payment schedule.

J. Protection of Enrollee-Provider Communications

1. In accordance with 42 USC §1396 u-2(b)(3), the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following:

a. The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. Any information the Enrollee needs in order to decide among all relevant treatment options;

c. The risks, benefits, and consequences of treatment or non-treatment; and

d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2. Notwithstanding the provisions of **Subsection 5.1.J.1.** above, and subject to the requirements set forth below, the Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows:

a. To EOHHS:

1) With its application for a Medicaid contract; and

2) At least 60 days prior to adopting the policy during the term of the Contract.

b. To Potential Enrollees, via enrollment materials, at least 30 days prior to adopting the policy during the term of the Contract.

c. To Enrollees, at least 30 days prior to adopting the policy during the terms of the Contract.

K. Protecting Enrollee from Liability for Payment

The Contractor must:

1. In accordance with 42 USC §1396 u-2(b)(6), not hold an Enrollee liable for:

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

b. Services (other than Excluded Services) provided to the Enrollee in the event that the Contractor fails to receive payment from EOHHS or CMS for such services; or

c. Payments to a clinical Subcontractor in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in **Subsection 5.1(K)(5)** below;

3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a bill that has not been paid; and

5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to identify and sanction any member of the Contractor's Provider Network that does not comply with such provisions.

Section 5.2 Program Integrity Requirements

A. Program Integrity Requirements

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:

1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards;
2. Provision for internal monitoring and auditing;
3. Provision for prompt response to detected offenses, and for development of corrective action initiatives;
4. The designation of a compliance officer and a compliance committee that are accountable to senior management;
5. Effective training and education for the compliance officer and the Contractor's employees;
6. Effective lines of communication between the compliance officer and the Contractor's employees; and,
7. Enforcement of standards through well-publicized disciplinary guidelines.

B. Fraud and Abuse Prevention, Detection and Reporting

The Contractor shall:

1. Develop a comprehensive internal fraud and abuse program, as part of the Contractor's compliance program to prevent and detect program violations;
2. Not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution In conformance with M.G.L. c. 12, §5J;
3. 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 reason to believe that a Provider, an Enrollee, or a Contractor employee, has engaged in fraud or abuse. For each complaint of fraud and abuse that warrants a preliminary investigation, report to EOHHS the name and identification number of the Enrollee/Provider, the source of the complaint; the type of Provider; the nature of the complaint; the approximate dollars involved and the legal and administrative disposition of the preliminary investigation;
4. Make diligent efforts to avoid or recover any improper payments or funds misspent due to fraudulent or abusive actions by the Contractor, or its parent organization, its Providers or its Subcontractors;

5. Require Providers to implement corrective actions or terminate Provider agreements, as appropriate;

6. Notify EOHHS in writing within ten (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 Member 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 Member on that specific matter without EOHHS's approval; and

7. The Contractor and, where applicable, its Subcontractors shall cooperate fully with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) 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.

C. Employee Education about False Claims Laws

1. The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least $5 million during the prior Federal fiscal year.

2. If the Contractor is subject to such federal requirements, the Contractor must:

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

   b. 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

   c. Initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

3. Failure to comply with this section may result in intermediate sanctions in accordance with this Contract.

Section 5.3 Continuity of Operations Plan

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

Section 5.4 Privacy and Security of Personal Data and HIPAA Compliance

A. Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health information), including, but not limited to, requirements set forth in M.G.L. c. 66A, 42 CFR 431, Subpart F, and 45 CFR Parts 160, 162 and 164. The Contractor understands and agrees that EOHHS may require specific written assurances and further agreements regarding the security and privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 CFR, parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in course of fulfilling its obligations under this Contract in accordance with applicable State and federal laws.

B. Personal Data

The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

C. Data Security

The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member or Enrollee names.

D. Return of Personal Data

The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of EOHHS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by EOHHS, will destroy such data or material.

Section 5.5 General Terms and Conditions

A. Applicable Law

The term "applicable law," as used in this Contract, means, without limitation, all statutes, orders, rules and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, all applicable law includes Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the Byrd Anti-Lobbying Amendment; Equal Employment Opportunity requirements, as provided in 41 CFR 60; and Titles XVIII and XIX of the Social Security Act.

B. Massachusetts Law

The laws of the Commonwealth of Massachusetts govern this Contract, including all rights, obligations, matters of construction, validity, and performance.

C. Massachusetts Appropriations Law

All MassHealth Contract payments hereunder are subject to appropriation pursuant to M.G.L. c.29, §26, and will be limited to the amount appropriated therefore to the extent permitted under applicable federal and State laws.

D. Sovereign Immunity

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts or EOHHS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

E. Advance Directives

The Contractor shall comply with the requirements of 42 CFR Part 438.6(i) and 130 CMR 450.112, relating to the maintenance of written policies and procedures regarding advance directives. The Contractor shall provide Enrollees with written information about its advance directives policies, including a written description of applicable Massachusetts law, reflecting any changes in Massachusetts law within ninety days of the change.

F. Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its Subcontractors incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to EOHHS and CMS. Such loss may be grounds for termination of this Contract under the provisions of **Subsection 5.7**.

G. Indemnification

The Contractor shall indemnify and hold harmless EOHHS, CMS, the federal government, and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS and CMS, or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its Subcontractors provided that:

1. The Contractor is notified of any claims within a reasonable time from when EOHHS and CMS become aware of the claim; and
2. The Contractor is afforded an opportunity to participate in the defense of such claims.
3. In accordance with 42 U.S.C. § 1396u-2, 42 CFR 438.6(d), 42 CFR 438.210(a)(3)(ii), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against a MassHealth Member eligible to enroll in the Senior Care Options Program on the basis of health status, need for health care services, diagnosis, illness, race, color or national origin.

H. Prohibition against Discrimination

1. In accordance with 42 USC §1396 u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any medical care practitioner who is acting within the scope of the practitioner's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines a request to include individual or groups of practitioners in its network, it must give the affected practitioners written notice of the reasons for its decision. This section shall not be construed to prohibit the Contractor from including Providers only to the extent necessary to meet the needs of the Contractor's Enrollees, or from using different reimbursement for different Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.
2. If a Complaint or claim against the Contractor is presented to the Massachusetts Commission Against Discrimination (MCAD), the Contractor shall cooperate with MCAD in the investigation and disposition of such Complaint or claim.
3. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.6(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against a MassHealth Member eligible to enroll in the Senior Care Options Program on the basis of health status, need for health care services, race, color or national origin.

I. Anti-Boycott Covenant

During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, EOHHS will be entitled to rescind this Contract in the event of noncompliance with this **Subsection 5.5(I)**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

J. Information Sharing

During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and State laws, the Contractor must arrange for the transfer, at no cost to EOHHS, or the Enrollee, of medical information regarding such Enrollee to any subsequent Provider of medical services to such Enrollee, as may be requested by the Enrollee or such Provider or directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to Enrollees who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

K. Other Contracts

Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide EOHHS with a complete list of such plans and services, upon request. EOHHS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other Provider, in the same Service Area.

L. Counterparts

This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

M. Entire Contract

This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated

herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

N. No Third-Party Rights or Enforcement

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

O. Corrective Action Plan

If, at any time, EOHHS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. EOHHS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by EOHHS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by EOHHS or other intermediate sanctions as described in **Subsection 5.5.P**.

P. Intermediate Sanctions

1. In addition to termination under **Subsection 5.7**, EOHHS may, in their sole discretion, impose any or all of the sanctions in **Subsection 5.5(P)(2**) upon any of the events below; provided, however, that EOHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Before imposing any sanction, EOHHS shall give the Contractor timely written notice that explains the basis and nature of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:

    a. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

    b. Imposes charges on Enrollees in excess of any permitted under this Contract;

    c. Discriminates among Enrollees on the basis of health status or need;

    d. Misrepresents or falsifies information provided to EOHHS, Enrollees, MassHealth Members, or its Provider Network;

    e. Fails to comply with requirements regarding physician incentive plans (see **Subsection 5.1(G**));

    f. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

    g. Violates restrictions or other requirements regarding marketing;

h. Fails to comply with quality management requirements consistent with **Subsection 2.10**;

i. Fails to comply with any corrective action plan required by EOHHS;

j. Fails to comply with financial solvency requirements;

k. Fails to comply with reporting requirements; or

l. Fails to comply with any other requirements of this Contract.

2. In accordance with 42 CFR 438.702, sanctions may include, but are not limited to:

a. Financial penalties;

b. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);

c. Suspension of enrollment (including assignment of Enrollees);

d. Suspension of payment to the Contractor;

e. Disenrollment of Enrollees; and

f. Service Area limitations.

3. If EOHHS have identified a deficiency in the performance of a Subcontractor and the Contractor has not successfully implemented an approved corrective action plan in accordance with **Subsection 5.5(O)**, EOHHS may:

a. Require the Contractor to subcontract with a different Subcontractor deemed satisfactory by EOHHS; or

b. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

4. In accordance with 42 CFR.438.726, capitation payments to the Contractor will be denied by EOHHS for new Enrollees when, and for so long as, payment for those Enrollees is denied to EOHHS by CMS under 42 CFR 438.730(e).

Q. Additional Administrative Procedures

EOHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

R. Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

S. Conflict of Interest

Neither the Contractor nor any Subcontractor may, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive.

T. Insurance for Contractor's Employees

The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of EOHHS, provide certification of professional liability insurance coverage.

U. Key Personnel

If the Contractor wishes to substitute another individual for the individual identified in **Subsection 2.2**, the Contractor must notify EOHHS and CMS immediately and provide the name of a suitable replacement. Upon EOHHS or CMS request, the Contractor must provide EOHHS and CMS with the resumé of the proposed replacement and offer EOHHS and CMS an opportunity to interview the person. If EOHHS and CMS are not reasonably satisfied that the proposed replacement has ability and experience comparable to the originally approved personnel, EOHHS and CMS will notify the Contractor within 10 business days after receiving the resumé and completing any interview. The Contractor must then propose another replacement for approval. This process must be repeated until EOHHS and CMS approve new key personnel.

If EOHHS and CMS are concerned that the person identified in **Subsection 2.2** is not performing responsibilities required by this Contract, EOHHS and CMS will inform the Contractor of this concern. The Contractor must investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS and CMS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by EOHHS and CMS, the corrective action provisions in **Subsection 5.5(O)** will be invoked by EOHHS and CMS.

V. Waiver

The Contractor, EOHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay

or omission on the part of the Contractor, EOHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by EOHHS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

W. Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

Section 5.6 Record Retention, Inspection, and Audit

A. Record Retention

The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for six years.

B. Inspection and Audit

1. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by EOHHS and CMS and other regulatory agencies, available to EOHHS and CMS and their agents, designees or contractors or any other authorized representatives of the Commonwealth of Massachusetts or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.
2. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its Subcontractors that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.
3. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that EOHHS or CMS may require, in a manner that meets EOHHS and CMS record maintenance requirements.
4. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through six years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and State requirements.

Section 5.7 Termination of Contract

A. Termination without Prior Notice

In the event the Contractor fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, EOHHS may take any or all action under this Contract, law, or equity. Without limiting the above, if EOHHS determine that the continued participation of the Contractor in the Medicare or MassHealth program may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or MassHealth program, EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity.

B. Termination with Prior Notice

Any party may terminate this Contract without cause upon no less than 180 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise.

C. Continued Obligations of the Parties

1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contactor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.
2. In the event that this Contract is terminated, expires, or is not renewed for any reason:
    a. If EOHHS, or both, elect to terminate or not renew the Contract, EOHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;
    b. The Contractor must promptly return to EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

c. The Contractor must supply to EOHHS all information necessary for the payment of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

D. Pre-Termination Hearing, When Required

In accordance with 42 CFR 438.10 (b), EOHHS will provide the Contractor with a pre-termination hearing, if the reason for the termination of the Contract is because the Contractor either: a) failed to carry out the substantive terms of its contract or b) failed to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Medicare Act.

Section 5.8 Order of Precedence

A. The following documents are incorporated into and made a part of this Contract:

1. **Appendices A through F** to this Contract; and
2. Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.

B. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

1. The Contract terms and conditions;
2. **Appendices A through F** to this Contract; and
3. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.

Section 5.9 Contract Term

This Contract shall be in effect for a period of one year, from **January 1, 2013** through **December 31, 2013**. At the option of EOHHS, the Contract may be extended for up to five additional one-year terms. EOHHS may exercise its extension option by providing written notice to the Contractor of its intent to do so at least sixty days prior to the expiration of the Contract term. The extension shall be under the same terms and conditions as the initial terms.

Section 5.10 Amendments

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

Section 5.11 Written Notices

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To EOHHS:
Kenneth Smith, Director
MassHealth Office of Long Term Services and Supports
One Ashburton Place, 5th floor
Boston, MA 02108

With copies to:

General Counsel
Executive Office of Heath and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

To the Contractor:
[TBD]

Appendices to the SCO Contract

Appendix A: Covered Services

Appendix B: Required Information to be Included in the Evidence of Coverage

Appendix C: Requirements for Provider Agreements & Subcontracts

Appendix D: Reporting Requirements

Appendix E: Capitation Rates

Appendix F: Cities and Zip Codes in Greater Boston Region

Appendix A

Covered Services

The Contractor is responsible for providing the following Medicare and Medicaid Covered Services, as authorized by the Primary Care Physician or the Primary Care Team, in accordance with the clinical protocols developed by the Contractor. The Contractor may offer additional services, in accordance with clinical protocols developed by the Contractor.

Ambulatory Surgery — all outpatient surgical services and related diagnostic and medical services.

Adult Day Health — community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, nutrition at a site outside the home, and transportation to a site outside the home.

Adult Foster Care/Adult Group Care — daily assistance in personal care, managing medication, meals, snacks, homemaking, laundry, and medical transportation.

Audiologist — audiologist exams and evaluations. See related hearing aid services.

Behavioral Health Services — see **Appendix A, Exhibit 1**.

Chiropractic Services — chiropractic manipulative treatment and radiology services.

Community-Based Services — including but not limited to the following services: homemaker; personal care; respite care; dementia and social day care; environmental accessibility adaptations; transportation; chore and companion; and respite.

Day Habilitation — a structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled individuals who need active treatment.

Dental Services — including but not limited to the following services: emergency care visits, including X-rays; extractions; dentures; and oral surgery.

Dialysis — including: laboratory; prescribed drugs; tubing change; adapter change; hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis; and training related to dialysis services.

Durable Medical Equipment (DME) and Medical/Surgical Supplies

1. **durable medical equipment** — products that are: (a) fabricated primarily and customarily to fulfill a medical purpose; (b) generally not useful in the absence of illness or injury; (c) able to withstand repeated use over an extended period of time; and (d) appropriate for home use. Includes but is not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals), walkers, commodes, special beds, monitoring equipment, orthotic and prosthetic devices, and the rental of Personal Emergency Response Systems (PERS). Coverage includes related supplies and repair and replacement of the equipment.

2. **medical/surgical supplies** — medical/treatment products that: (a) are fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) are used in the treatment of a specific medical condition; and (c) are non-reusable and disposable. Includes but is not limited to items such as urinary catheters, wound dressings, glucose monitors, and diapers.

Emergency Services — covered inpatient and outpatient services, including behavioral health services, that are furnished to an Enrollee by a provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition. Emergency services include post-stabilization services provided after an emergency is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer.

Geriatric Support Services Coordination — services provided by a licensed social worker in accordance with **Subsection 2.4(A)(5)** of the Contract.

Hearing Aid Services — including but not limited to diagnostic services, hearing aids or instruments, and services related to the care and maintenance of hearing aids or instruments.

Home Health — all home health care services, including DME associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.

Hospice — a package of services such as nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aid; medical supplies, drugs, biological supplies; and short term inpatient care.

Inpatient Hospital Services— all inpatient services, including but not limited to physician, surgery, radiology, nursing, laboratory, other diagnostic and treatment procedures, blood and blood derivatives, semi-private or private room and board, drugs and biologicals, medical supplies, durable medical equipment, and medical surgical/intensive care/coronary care unit, as necessary, at any of the following settings:

1. acute inpatient hospital;
2. chronic hospital;
3. rehabilitation hospital; or
4. psychiatric hospital.

Institutional Care — services such as nursing, medical social work, assistance with activities of daily living, therapies, nutrition, and drugs and biologicals provided at a skilled nursing facility or other nursing facility.

Laboratory — all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees.

Orthotics — braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body, including therapeutic shoes for Enrollees who have diabetic foot disease.

Oxygen and Respiratory Therapy Equipment — ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.

Personal Care Attendant Services — assistance with Activities of Daily Living (ADLs) such as bathing, dressing, grooming, eating, ambulating, toileting, and transferring.

Pharmacy — legend and non-legend drugs that are reasonable and necessary for the diagnosis or treatment of illness or injury. Legend drugs must also be approved by the U.S. Food and Drug Administration.

Physician (primary) — annual exams and continuing care, including medical, radiological, laboratory, anesthesia and surgical services.

Physician (specialty) — physician specialty services, including but not limited to the following list and second opinions upon the request of the Enrollee:

Anesthesiology	Neurology	Psychiatry
Audiology	Neurosurgery	Pulmonology
Cardiology	Oncology	Radiology
Dentistry	Ophthalmology	Rheumatology
Dermatology	Oral surgery	Surgery
Gastroenterology	Orthopedics	Thoracic surgery
Gynecology	Otorhinolaryngology	Vascular surgery
Internal Medicine	Podiatry	Urology
Nephrology		

Podiatry —care for medical conditions affecting the lower limbs, including routine foot care as defined by Medicare in Part III, Section 2323 of the Medicare Carriers Manual.

Private Duty Nursing — continuous, specialized skilled nursing services.

Prosthetic Services and Devices — prosthetic devices, including the evaluation, fabrication, and fitting of a prosthesis. Coverage includes related supplies, repair, and replacement.

Radiology and X-ray — all X-rays, including portable X-rays, magnetic resonance imagery (MRI), radiation therapy, and radiological services.

Therapy — individual treatment (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device), comprehensive evaluation, and group therapy.

1. **Physical —** evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular , and respiratory systems.

2. **Occupational —** evaluation and treatment of an Enrollee in his or her own environment for impaired physical functions.

3. **Speech and Hearing —** evaluation and treatment of speech, language, voice, hearing, fluency, and swallowing disorders.

Transportation — ambulance (air and land), taxi, and chaircar transport for medical reasons.

Vision Care Services — the professional care of the eyes for purposes of diagnosing and treating all pathological conditions. They include eye examinations, vision training, prescriptions, and glasses and contact lenses.

Appendix A

Exhibit 1: Behavioral Health (BH) Services

A. Inpatient Services — twenty-four-hour services that provide medical intervention for mental health or substance abuse diagnoses, or both, including:

1. **Inpatient Mental Health Services —** hospital services to stabilize an acute psychiatric condition that: 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or other; or 4) has resulted in marked psycho-social dysfunction or grave mental disability.

2. **Detoxification —** Inpatient substance-abuse services that provide short-term medical treatment for substance-abuse withdrawal, individual medical assessment, evaluation, intervention, substance-abuse counseling, and post-detoxification referrals. These services may be provided in licensed freestanding or hospital-based programs.

B. Diversionary Services — those BH services that are provided as alternatives to inpatient services, including:

1. **Community Support —** services provided in a community setting, which are used to prevent hospitalization, and designed to respond to the needs of Enrollees whose pattern of utilization of services or clinical profile indicates high risk of readmission into 24-hour treatment settings.

2. **Crisis Stabilization —** services provided as an alternative to hospitalization which provides short-term psychiatric treatment in structured, community based therapeutic environments. Crisis stabilization provides continuous 24-hour observation and supervision for individuals who do not require the intensive medical treatment of hospital level of care.

3. **Observation/Holding Beds —** services to provide hospital level care for up to 24 hours to provide time for assessment, stabilization, and identification of appropriate resources for individuals.

4. **Partial Hospitalization —** an alternative to Inpatient Mental Health Services which offers short-term day mental health programming available seven days per week consisting of therapeutically intensive acute treatment within a stable therapeutic milieu and including daily psychiatric management.

5. **Psychiatric Day Treatment —** services that constitute a program of a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual provider's office, or hospital outpatient department, but who do not need full-time hospitalization or institutionalization.

6. **Residential Substance Abuse Treatment —** short-term 24-hour therapeutically planned treatment and learning situation that provides continuity of care after detoxification for individuals engaging in recovery.

7. **Structured Outpatient Addiction Programs —** short-term clinically intensive structured day or evening substance-abuse services. Such a program can serve as a step-down service in the continuum of care for individuals being discharged from detoxification or can be utilized by individuals whose symptoms indicate a need for structured outpatient treatment beyond the standard outpatient benefit.

C. BH Emergency Services — Medically necessary services that are available seven days per week, 24 hours per day to provide treatment of any Enrollee who is experiencing a mental health or substance abuse problem, or both, including:

1. **Emergency Screening Services —** a face-to-face assessment, conducted by appropriate clinical personnel, of an individual presenting with an emergency in a home, residential program, clinic, hospital emergency room, police station, and other settings.

2. **Medication Management Services —** assessment for and prescribing of medication by qualified personnel as a component of emergency services.

3. **Short Term Crisis Counseling —** provision of individual therapy as a component of emergency services.

4. **Short-Term Crisis Stabilization Services —** any or all of the following: (1) Crisis Stabilization; (2) Observation/Holding Beds; (3) Specialing Services; (4) Medication Management Services; and (5) Short-Term Crisis Counseling.

5. **Specialing Services —** therapeutic services provided to an individual, in a variety of settings, on a one-to-one basis to maintain the individual's safety as a component of BH Emergency Services.

D. Outpatient Services – BH services provided in an ambulatory care setting, such as a mental health or substance abuse clinic, hospital outpatient department, community health center, or Provider's office, including:

1. Mental Health

a. Evaluation

b. Treatment

c. Medication

d. Consultation

2. Substance Abuse Services

a. Counseling

b. Diagnostic Evaluation

c. Medication Visit

E. Special Procedures

1. Electro-Convulsive Therapy — service that initiates seizure activity with an electric impulse while the Enrollee is under anesthesia. It is administered in a hospital facility that is licensed to provide this service by the Department of Mental Health.

2. Psychological Neuropsychological Testing — the use of standardized test instruments when indicated for behavioral or physical health reasons to evaluate aspects of an Enrollee's functioning, including but not limited to cognitive processes, emotional conflicts, and type and degree of psycho-pathology.

Appendix B

Required Information to be Included in the Evidence of Coverage

A. Welcome and Overview of SCO

B. Features of SCO

Primary Care Physician
Primary Care Team
One Source for All Your Care
Facilities
Coordination of Services with Medicare and Medicaid
Services Provided Exclusively through SCO

C. Eligibility

D. Enrollment

Step 1: Intake
Step 2: Assessment
Step 3: Preliminary Approval
Step 4: Final Approval and Enrollment
Appeals Process

E. Benefits and coverage

Outpatient Health Services
Inpatient Hospital Care
Nursing Home Care
Home Health Care
End-of Life Care
Health-Related Services
Dental Care

F. Exclusions and Limitations

G. Access to After-Hours Care and Emergency Care

After-Hours Care
Emergency Care
Out-of-Area Urgently Needed Care

H. Complaints and Appeals (in accordance with 42 C.F.R. 438.100)

Complaint Process
Appeals Process
You Have a Right to Appeal
Support for Your Appeal
Who May File an Appeal
If You Want Someone to File an Appeal for You
Help with Your Appeal

I. Your Rights as an Enrollee (in accordance with 42 C.F.R. 438.100)

The extent to which, and how, Enrollees may obtain benefits, including family planning services, from out of network providers.

J. Other Contract Provisions

Termination Benefits
Voluntary Disenrollment
Involuntary Disenrollment
Renewal Provisions
Changes to Your Contract
Continuation of Services after Termination
Cooperation from You
Governing Law
Assignment of Benefits
Notifications
Notice of Certain Events
Policies and Procedures Adopted by the SCO
Time Limitations on Claims
Access to Your medical Records
Waiver of Conditions for Care
Who Receives Payment under this Plan?

K. Definitions

Appendix C

Requirements for Provider Agreements and Subcontracts

The Contractor shall:

A. Enter into Provider Agreements only with qualified or licensed providers who meet federal and State requirements when applicable;

B. Maintain a supplier/vendor management program that proactively requires the Contractor's major Providers of services (for example, hospitals, pharmacies, home health providers, laboratory services, and radiology services) to conduct activities to monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. In addition, management and clinical data from the Provider must be submitted to the Contractor in a format compatible with the Contractor's information systems. (Such data must be incorporated with the Contractor's utilization and cost data and submitted to EOHHS where required under the Contract.);

C. Maintain all Provider Agreements and other agreements and subcontracts relating to this Contract in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 CFR Part 438, including the requirement that Providers in the Contractor's Provider Network offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to MassHealth fee for service enrollees; and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity;

D. Actively monitor the quality of care provided to Enrollees under any Provider Agreements and any other subcontracts;

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

F. Prior to any delegation to a Subcontractor, evaluate the prospective Subcontractor's ability to perform the activities to be delegated;

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

H. Monitor any 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 Subcontractor shall take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of such annual review and any corrective action plans developed as a result;

I. Notify EOHHS in writing at least 60 days prior to procurement or reprocurement of services provided by any Subcontractor;

J. Provide EOHHS with information, in response to all questions posed by EOHHS, regarding implementation plans to ensure readiness for transition to a new Subcontractor;

K. Notify EOHHS in writing immediately upon notifying any Subcontractor or being notified by any Subcontractor of the intention to terminate such subcontract;

L. Inform EOHHS if any of its Subcontractors are certified Minority Business Enterprises;

M. Ensure that all Provider Agreements include the following provision: *"Providers shall not seek or accept payment from any Enrollee for any SCO Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any SCO Covered Service rendered to an Enrollee. Instead, Providers shall look solely to (Contractor's name) for payment with respect to SCO Covered Services rendered to Enrollees. Furthermore, Providers shall not maintain any action at law or in equity against any Enrollee or EOHHS to collect any sums that are owed by(Contractor's name) for any reason, even in the event that (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of its agreement with the Provider or any other agreement entered into by (Contractor's name)."*

N. Ensure that all Provider Agreements and subcontracts contain at least the following provisions:

    1. Specification that the subcontract be governed by and construed in accordance with all laws, regulations, and contractual obligations incumbent upon the Contractor, including any applicable requirements specified in the Contract;

    2. Subcontractor's agreement to accept the Contractor's payment as payment in full and not to bill Enrollees, EOHHS or CMS;

    3. Subcontractor's agreement to hold harmless EOHHS, CMS, and Enrollees in the event that the Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the subcontract;

    4. Subcontractor's agreement that assignment or delegation of the subcontract is prohibited unless prior written approval is obtained from the Contractor; and

    5. Subcontractor's agreement to make all books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination, or copying by EOHHS and CMS.

O. Provide adequate and appropriate stop-loss protection if incentive arrangements with the subcontractor place the subcontractor at substantial financial risk for services it does not provide; and

P. Make best efforts to ensure that all subcontractor agreements stipulate that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Subcontractor is based.

Appendix D

Reporting Requirements

The Contractor must report performance, as required by the Contract, to EOHHS and CMS through financial statements and ratios, using the financial indicators and according to the definitions below. These indicators are intended to measure the liquidity, efficiency, composition, capitalization, and profitability of the Contractor, in accordance with generally accepted accounting principles. The Contractor must provide reports to EOHHS and CMS quarterly, or on a monthly basis as directed by EOHHS and CMS, including documentation and an explanation of any deviations from the standards as defined below. All reports must contain: 1) a subsection for the Contractor's activity only; and 2) a subsection for a consolidated report, including combined data for the Contractor and all subcontractors.

I. Liquidity

A. Current ratio

Definition: Current Assets/Current Liabilities

Purpose: To measure the Contractor's ability to meet short-term obligations with cash or other assets readily convertible to cash.

B. Acid test

Definition: (Current Assets – Accounts Receivable)/ Current Liabilities

Purpose: To measure the Contractor's ability to meet its short-term obligations with cash or other assets readily convertible to cash, excluding accounts receivable.

C. Cash to Claims and Payables

Definition: (Cash and Cash Equivalents)/Claims and Payables

Purpose: To measure the Contractor's ability to pay off claims and accounts payable with all available sources of cash.

D. Days of Total Claims Incurred But Not yet Reported (IBNR)

Definition: Total IBNR Claims (estimated)/(Total Medical Claims/365)

Purpose: To determine the number of days of claims owed to providers by the Contractor, in order to measure the ability of the Contractor to cover future claims.

E. Claims as a percentage of Revenue

Definition: Claims Payable/Total Revenue

Purpose: To measure the efficiency of the Contractor's claims management system.

II. Efficiency

A. Medical Expense Ratio

Definition: Total Medical Costs/Total Revenue

Purpose: To measure the extent to which the Contractor has been able to control costs.

B. Medical Expense Per Member Per Month (PMPM)

Definition: Total Medical Costs/Member Months

Purpose: To identify trends in the costs of the Contractor's delivery of health care on a per member per month basis.

C. Administrative Expense Ratio

Definition: Total Administrative Costs/Total Revenue

Purpose: To measure the efficiency of the Contractor's management of its operations.

III. Composition

A. Receivables to Current Assets

Definition: Accounts receivable/Current Assets

Purpose: To determine the extent to which receivables make up total current assets.

B. Cash to Current Assets

Definition: Cash/Current Assets

Purpose: To determine the extent to which cash makes up total current assets.

IV. Capitalization

A. Debt Ratio

Definition: Total Debt/Total Assets

Purpose: To determine Contractor's capacity to pay its debts.

B. Debt Service Coverage

Definition: Total Interest on Debt/Total Non-fixed Assets

Purpose: To determine Contractor's capacity to pay interest on its debts.

V. Profitability

A. Net Profit Margin

Definition: Net Income/Total Revenue

Purpose: To determine Contractor's ability to generate a profit.

B. Net Worth

Definition: Total Assets — Total Liabilities

Purpose: To determine the degree of Contractor's solvency.

VI.

Equity Per Enrollee

Definition: Total Equity/Total Enrollees

Purpose: To determine Contractor's ability to support operations on a per Enrollee basis.

VII. Other Data to Be Reported

A. Quarterly Reports

The Contractor shall report the following data on a quarterly basis:

1. Financial Experience Review

This report shall contain utilization, average unit cost, and PMPM total cost by categories of service, and by categories of Enrollee, as specified by EOHHS, for all services provided to Enrollees.

2. Income/Expense Report

This report shall contain enrollment data, in member-months, and revenue and expense data. The revenue data shall report capitation income and other income, and the expense data shall report costs by type of provider, including adjustments and other indirect costs.

3. Working Capital Report

This report shall contain information on the Contractor's working capital (defined as current assets minus current liabilities), as required by **Subsection 2.12(A)(2).**

4. Member Enrollment and Disenrollment

This report shall contain the Contractor's enrollment and disenrollment data.

B. Annual Reports

The Contractor shall report the following data on an annual basis:

1. Balance sheet;

2. Income and expense statement;

3. Statement of changes in financial position;

4. Capital expenditure; and

5. Projected financial position throughout the duration of the Contract, which satisfies the standards of the American Institute of Certified Public Accountants (AICPA).

VIII. Other M+C Financial Reports at 42 CFR 422.502 and 516

IX. Non-Financial Reports

A. Annual reports on progress toward reaching established quality management goals in accordance with **Subsection 2.10**.

B. HEDIS measures (clinical indicator data) in accordance with **Subsection 2.14(A).**

C. Monthly report of number and types of complaints and appeals filed by Enrollees as well as how and in what time frames they were resolved in accordance with **Subsection 2.14(D).** Also include relevant information from the annual analysis of Enrollee Surveys in accordance with **Subsection 2.10(F).**

D. Utilization Data in accordance with **Subsection 2.14(F) and (G).**

E. Quarterly report on Enrollees who are medically eligible for nursing facility services, by age group and gender in accordance with **Subsections 2.14(H).**

F. Encounter data requirements at 42 CFR 422.502 (a) (8) in accordance with **Subsections 2.14(B).**

Appendix E

Capitation Rates

Rates for Contract Years 2011 and 2012
(Subject to CMS Approval)

	Other	AD/CMI	NHC	Tier 1	Tier 2	Tier 3
Dually Eligible Outside Greater Boston	RC 21 $172.43	RC 23 $395.52	RC 25 $3,089.34	RC 26 $4,512.86	RC 27 $6,775.55	RC 28 $8,609.06
MassHealth Only, Outside Greater Boston	RC 31 $620.74	RC 33 $1,521.31	RC 35 $5,970.94	RC 36 $4,512.86	RC 37 $6,775.55	RC 38 $8,609.06

APPENDIX F

Cities and Zip codes in Greater Boston Region

City	Zip Code
Accord	02018
Allston	02134
Arlington	02474
Arlington	02476
Arlington Heights	02475
Babson Park	02457
Boston	02101
Boston	02102
Boston	02103
Boston	02104
Boston	02105
Boston	02106
Boston	02107
Boston	02108
Boston	02109
Boston	02110
Boston	02111
Boston	02112
Boston	02113
Boston	02114
Boston	02115
Boston	02116
Boston	02117
Boston	02118
Boston	02119
Boston	02120
Boston	02122
Boston	02123
Boston	02124
Boston	02125
Boston	02126
Boston	02127
Boston	02128

Boston	02129
Boston	02130
Boston	02131
Boston	02132
Boston	02133
Boston	02134
Boston	02135
Boston	02136
Boston	02137
Boston	02163
Boston	02196
Boston	02199
Boston	02201
Boston	02202
Boston	02203
Boston	02204
Boston	02205
Boston	02206
Boston	02207
Boston	02208
Boston	02209
Boston	02210
Boston	02211
Boston	02212
Boston	02215
Boston	02216
Boston	02217
Boston	02222
Boston	02228
Boston	02241
Boston	02266
Boston	02283
Boston	02284
Boston	02293
Boston	02295
Boston	02297
Boston	02455
Braintree	02184
Braintree	02185

Brighton	02135
Brookline	02445
Brookline	02446
Brookline Village	02447
Cambridge	02138
Cambridge	02139
Cambridge	02140
Cambridge	02141
Cambridge	02142
Cambridge	02163
Cambridge	02238
Cambridge	02239
Charlestown	02129
Chelsea	02150
Chestnut Hill	02467
Cohasset	02025
Dedham	02026
Dedham	02027
Dorchester	02121
Dorchester	02122
Dorchester	02124
Dorchester	02125
East Boston	02128
East Boston	02228
Greenbush	02040
Hingham	02018
Hingham	02043
Hingham	02044
Hull	02045
Hyde Park	02136
Hyde Park	02137
Jamaica Plain	02130
Mattapan	02126
Milton	02186
Milton Village	02187
Minot	02055
Newton	02458
Newton	02459
Newton	02460

Newton	02461
Newton	02462
Newton	02464
Newton	02465
North Scituate	02060
Norwell	02061
Norwood	02062
Quincy	02169
Quincy	02170
Quincy	02171
Quincy	02269
Randolph	02368
Readville	02136
Readville	02137
Revere	02151
Roslindale	02131
Roxbury	02118
Roxbury	02119
Roxbury	02120
Scituate	02040
Scituate	02055
Scituate	02060
Scituate	02066
Somerville	02143
Somerville	02144
Somerville	02145
Waban	02468
Waverley	02479
West Roxbury	02132
Westwood	02090
Weymouth	02188
Weymouth	02189
Weymouth	02190
Weymouth	02191
Winthrop	02152