# Provider Manual

SEPTEMBER 2024

COMMUNITY CARE COOPERATIVE

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# Section 1: Introduction

## 1.1 Welcome!

### Dear Participating, Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers:

Thank you for being part of Community Care Cooperative (C3). This Provider Manual was created just for you. This manual serves as a resource and reference tool for our Participating FQHCs, and Affiliated Participating Providers, and their staff, to understand what it means to be a part of our community. This manual applies to FQHCs and Affiliated Participating Providers who participate in our **MassHealth ACO** and includes general information about C3 as well as comprehensive information related to our programs, regulatory requirements, and policies and procedures.

We developed this manual to help you get the most out of your relationship with us. Please read it carefully, and as always, reach out to us with any questions or concerns.

### Compliance

The Provider Manual includes information on our policies and procedures that are based on contractual requirements and best practices. Our Participating FQHCs and Affiliated Participating Providers are responsible for compliance with contractual requirements described in this manual, and within terms placed in the following contracts and regulations:

- Contract By and Between The Executive Office of Health and Human Services (EOHHS) and Community Care Cooperative, Inc. to serve as a Primary Care Accountable Care Organization for the Accountable Care Organization Program (EOHHS ACO Contract).
- The Primary Care Accountable Care Organization Participating Primary Care Provider Contract between EOHHS and our Participating FQHCs and Affiliated Participating Providers.
- Other relevant State and Federal regulations.

We created this manual to help you stay compliant with regulatory requirements. Please review it in its entirety.

### Terms and Definitions:

- "We," "us," "our," "the Organization," or "our Organization," means Community Care Cooperative (C3).
- "You," "your," or "your providers," refers to Participating Federally Qualified Health Centers and Affiliated Participating Providers.

### Provider Manual Updates

This manual will be amended based on regulatory, policy, or process changes. During the calendar year, all updates will be communicated with our Participating FQHCs and Affiliated Participating Providers via addenda which will be available on our website.

All changes will be incorporated in the manual annually.

## 1.2 About C3

### General Information

Community Care Cooperative (C3) is a Federally Qualified Health Center-owned non-profit organization that provides scale and value to FQHCs and Affiliated Participating Providers through Accountable Care Organization (ACO), risk contracting and shared services.

In 2016, leaders from nine FQHCs throughout the State formed C3. As an innovative model for an Accountable Care Organization (ACO), C3 leverages the best practices of FQHCs and ACOs throughout the country. Our ACO is the only ACO in the State founded and governed by FQHCs.

C3 is building its organization on the collective strengths of Participating FQHCs and Affiliated Participating Providers. We partner with Health Centers and Affiliated Participating Providers across the State, and our continued growth and expansion enables us to better serve populations across the Commonwealth. We have expanded our contracts and work to devote our services to FQHCs throughout the country. We believe that our model of uniting FQHCs will advance primary care, improve finance performance, advance racial justice, and provide FQHCs with the tools and services to remain competitive in the ever-changing market landscape.

## Vision, Mission Statement, and Core Values

To leverage the collective strengths of Federally Qualified Health Centers (FQHCs) to improve the health and wellness of the people we serve.

Our Vision is to transform the health of underserved communities. To do so, we leverage the collective strengths of FQHCs and Affiliated Participating Providers to improve the health and wellness of the people we serve. We are committed to improving the health of the communities we serve, one person at a time.

**Our Core Values:**


## Diversity, Equity, and Racial Justice

Following the reawakening of the racial justice movement after the murder of George Floyd, our organization reaffirmed its commitment to diversity, equity, and racial justice. In response, our Board of Directors adopted a charter that established the Diversity, Equity, and Racial Justice (DERJ) Committee to lead our organization's efforts in this area.

Our 3-year DERJ Committee agenda focuses on four key objectives:

- Embedding Diversity, Equity, and Racial Justice into HR Policies and Practices: We are continuously reviewing and refining our HR policies to foster equal opportunities for all races in employment, compensation, promotion, and retention. A critical aspect of this objective is increasing the representation of Black, Indigenous, and People of Color (BIPOC) in leadership positions and across all levels of our organization's staffing structure.

- Inclusion: Through targeted training and the establishment of affinity groups, we have been nurturing an environment free from racism, unconscious bias, and other workplace practices that prevent BIPOC staff from reaching their full potential.
- Health Equity: Our Organization has begun routinely disaggregating performance data on quality and other program measures. This data is being used to ensure equity in outcomes for hypertension, diabetes, maternal morbidity, and behavioral health.
- Racial Justice: C3 is investing resources to promote racial justice in the communities we serve by increasing BIPOC representation in decision-making roles. One approach to achieving this goal is by supporting a pipeline of professionals through internship and fellowship programs that position them for future leadership opportunities. Additionally, we are working to diversify our vendor pool.

After three years of in-house DERJ efforts, we are now launching a 3-year plan to support our FQHCs in their own DERJ initiatives. This includes providing training to FQHC staff and providers on unconscious bias, racial justice and health equity, and disability-competent care (DCC). Over the next three years, we will deliver unconscious bias training through synchronous webinar sessions to maintain the interactive quality of the training. The other two trainings will be offered through asynchronous e-learning modules.

## Governance Structure

Federally Qualified Health Centers (FQHCs) in Massachusetts govern our Organization. Our governance structure incudes the Board of Directors and several committees:

- Executive Committee
- Patient Family and Advisory Committee (PFAC), which is responsible for driving and monitoring the subset of goals aligned with patient experience
- Quality Committee, which includes representation from physical health and behavioral health
- Health Equity Committee
- Finance, Audit, and Investment Committees
- Compliance Committee

## 1.3 Contact Information

| Community Care Cooperative (C3) Key Contact Information | | |
|---|---|---|
| **Functional Area** | **Telephone** | **E-mail** |
| Call Center: Customer Services & Member Advocates – Member Operations | 866-676-9226 (TTY: 711) | memberadvocates@c3aco.org |
| Compliance Officer & Compliance Department | NA | compliance@c3aco.org |
| Eligibility, Enrollment & Redetermination – Member Operations | 866-676-9226 | enrollment@c3aco.org |
| Grievance Filing and Reporting – Member Operations | 866-676-9226 | grievances@c3aco.org |
| Population Health IT Support | NA | c3support@c3aco.org |
| Provider Data Management – Member Operations | NA | providerchange@c3aco.org |

| Other Contact Information | | |
|---|---|---|
| **Organization/Functional Area** | **Telephone** | **E-mail** |
| MassHealth Customer Service | 800-841-2900 (TTY/TDD: 711) | NA |
| MassHealth Drug Utilization Review Program (for Providers) | 800-745-7318 | NA |
| MassHealth Pharmacy Help Desk | 866-246-8503 | masshealth.provider@conduent.com |
| Massachusetts Behavioral Health Partnership (MBHP) | 800-495-0086 (TTY/TDD: 711) | NA |

# Section 2. Member Eligibility, Enrollment, MassHealth Renewal (Redetermination), and other Member Information

## 2.1 Eligibility Criteria

### MassHealth ACO Eligibility

MassHealth Members are eligible for our ACO enrollment if they:

- are MassHealth Managed Care Organization (MCO) plan eligible;
- have a primary care provider (PCP) at one of our Participating FQHCs or Affiliated Participating Providers.

To be eligible for MassHealth's Managed Care Organization (MCO) plan and ACO, MassHealth Members must:

- have MassHealth Standard, CarePlus, CommonHealth, or Family Assistance coverage types;
- be younger than 65 with no other health insurance;
- live in the community.

For additional details on the MassHealth Managed Care (MCO) eligibility, please visit mass.gov.

Members who are not eligible for enrollment into the ACO program include:

- Dually-eligible Members (Medicaid/Medicare)
- Health Safety Net and MassHealth Limited enrollees
- Members with other primary medical insurance.

If a MassHealth Member is ACO program eligible and wants to continue receiving primary care services at one of our Participating Federally Qualified Health Centers (FQHCs) or Affiliated Participating Providers, the Member will need to select us as their ACO. If a patient is not enrolled in our ACO and is seen for primary care in the FQHC or Affiliated Participating Provider's practice, after the continuity of care period (COC) is over, the Health Center or Affiliated Participating Provider will not be paid for services. This rule does not apply to MassHealth Members who are in the MassHealth Fee-For-Service program. For

more information about COC, please see the *MassHealth Continuity of Care (COC)* in Section 2.2 below.

### MassHealth Eligibility Verification System (EVS)

Providers should use the MassHealth Eligibility Verification System (EVS Virtual Gateway) to verify Member eligibility before providing services. For access to the MassHealth EVS system, please contact MassHealth at 800-841-2900 or visit the MassHealth provider service center at newmmis-portal.ehs.state.ma.us/EHSProviderPortal/providerLanding/providerLanding.jsf.

## 2.2 Enrollment, Disenrollment, and MassHealth Renewal (Redetermination)

### ACO Enrollment Information

#### How to Change Plans

ACO enrollment is based on the Member selecting a plan and primary care provider. MassHealth may also automatically enroll Members using primary care provider records, the Member and PCP's location, and other data elements listed in MassHealth's system. In either case, MassHealth is the entity enrolling and disenrolling Members in and from an ACO plan.

Members may enroll, disenroll, or change their plan/ACO by doing the following:

- By calling the MassHealth Customer Service Center at 800-841-2900 (TTY/TDD: 711), Monday – Friday, 8 a.m. – 5 p.m. Self-service available 24 hours/day in English and Spanish.
- Online by completing an enrollment form on masshealthcoices.com: https://www.masshealthchoices.com/en/enroll This is the best way to enroll. Enrollment can be completed by the Member, appointed representative, parent or guardian, or a Massachusetts Navigator.
- By mailing or faxing the MassHealth Health Plan Enrollment Form or Change Form. The form and instructions can be downloaded from the MassHealth website: https://www.masshealthchoices.com/content/dam/digital/united-states/massachusetts/mah-bss/pdf/en/Health-Plan-Enrollment-Change-Form-EF-MCO-ENG-v8.pdf.

MassHealth Program
ATTN: Enrollment
P.O. Box 4405
Taunton, MA 02780

Fax number: 617-988-8903

To learn when Members can change their plans, please see the *ACO Plan (Open Enrollment) Selection and Fixed Enrollment Period* Section below. To learn about Members' choices in healthcare, please visit the MassHealth Enrollment Guide online: https://masshealthchoices.com/en/compare and masshealthchoices.com/member-materials.

## ACO Plan (Open Enrollment) Selection and Fixed Enrollment Period

Each year during the **90-day Plan Selection (Open Enrollment) Period**, Members can change their plan voluntarily without a specific reason. The Plan Selection Period begins on the Member's effective enrollment date into their first ACO/MCO. It recurs annually on the day of their enrollment into the ACO/MCO. MassHealth notifies Members when their Plan Selection Period starts. Members are not limited to how many times they can switch plans within 90 days of their Plan Selection Period.

If Members are happy with their existing plan and primary care provider, they do not have to make any changes. They will stay enrolled in their plan and continue receiving primary care services from their PCP.

Once the Plan Selection Period ends, Members will be in the **Fixed Enrollment Period** and will not be able to change health plans or ACOs except under certain circumstances that warrant an exception. All Members who are in the Fixed Enrollment Period must meet special exception criteria and provide ample supporting information for a plan transfer to be approved by MassHealth.

After a health plan/ACO change is requested, MassHealth will work to respond as quickly as possible, and will have up to 30 days to decide the exception. If the exception is granted, MassHealth Customer Service will notify the Member by phone and in writing of the approval and the effective date of the enrollment change.

If a Member decides to request an exception, MassHealth will start the process when one of the following reasons is provided:

- Personnel from their key network of providers, such as PCPs, specialists, or behavioral health providers, have left the plan network.

- The Member has moved out of their assigned health plan service area: Specifically, the Member moved to a new address in Massachusetts, and their current enrollment plan is not available in this area, or the old PCP office location is beyond a 25-mile radius.
- A geographic accommodation is needed for a homeless Member: Members can meet a geographic accommodation exception if their homeless status is reflected in MassHealth's system, and their current plan cannot accommodate their current geographic needs.
- There is language, communication, disability accommodations, or other accessibility needs being unmet.
- Due to inability to obtain related services: A Member needs related services to be performed, but not all related services are available within the network, and their primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk.
- There is limited provider care or access: A Member may be granted an exception if they maintain that their plan has not enabled access to providers that meet their health care needs over time, even after the Member requested assistance. This situation could arise if providers are unable to see Members at the intervals they need, if providers are not adequately treating the Member, or the Member cannot get appointments within a reasonable or required amount of time.
- The ACO violated a material provision of its contract with MassHealth: If a Member is aware of a violation of the plan contract, they can contact MassHealth for further review. However, MassHealth closely monitors the plan's compliance with their contract. MassHealth will also proactively notify Members if their enrollment needs to change due to a violation of the contract.
- A health plan left MassHealth or left Members' service area: Members can ask for an exception if their plan is no longer contracted with MassHealth to cover their service area or their PCP who participates in the ACO is not available in their service area.
- Plan is not meeting the Member's health needs: Members can pursue this exception if they receive inadequate quality care, lack access to services covered, or lack access to providers experienced in dealing with their health care needs.

- MassHealth imposes a sanction (penalty) on the plan: If MassHealth imposes a sanction on the plan, such as reduction of their membership, Members will be allowed to disenroll from a plan without cause. Members will be notified of the option to switch plans.
- A moral or religious objection: If the plan does not cover the requested service because of moral or religious objections. This exception may be met if the health plan has a moral or religious objection to covering a specific benefit or service.

**Members may also ask for an exception if they have an ongoing relationship with their PCP and were assigned to the wrong plan.** MassHealth will accept this reason as an exception. However, until the exception is granted, Members must use their current plan or ACO for services.

For urgent requests, MassHealth has established an escalation process to accommodate Members' needs. Members should inform MassHealth about their level of urgency.

For more information about how Members can change their health plans, please see the *How to Change Plans* Section above.

## MassHealth Continuity of Care (COC)

All new Members are eligible for a 30-day COC (transition) period upon the effective date of enrollment into a new ACO or MCO plan. During this time, new Members may continue to see their current providers for medically necessary services for at least 30 days after the effective date of enrollment with a new health plan. All existing prior authorizations for services and for provider referrals will be honored by MassHealth. Providers who were not in the MassHealth Primary Care Clinician (PCC) network must contact MassHealth to make appropriate payment arrangements.

In some circumstances, MassHealth may extend the COC period for Members who are automatically enrolled with C3 because, for example, their FQHC or provider joined our ACO. MassHealth will notify all appropriate parties about the extension if applicable. The COC period may also be extended because of the Member's medical condition. For example, Members who are pregnant can continue seeing their existing OB/GYN providers throughout their pregnancy and up to six weeks postpartum.

## Voluntary and Involuntary Disenrollment

### Voluntary Disenrollment

All Members enrolled in an ACO or MCO health plan have a 90-day Plan Selection Period every year based on their enrollment date with MassHealth. During this period, Members can decide if they want to stay with their current plan or switch to another plan without providing additional reasons for their disenrollment. If they want to switch to another plan for any reason, they will have to contact MassHealth.

MassHealth allows limited plan changes after the Plan Selection Period ends and when the Fixed Enrollment Period begins. Members must meet special criteria, ask for an exception, and receive approval from MassHealth. For more information about Voluntary Disenrollment, please see the *ACO Enrollment Information* Section above.

### Involuntary Disenrollment

The sections above provide information on Members' choices and voluntary enrollment and disenrollment options. This section describes several circumstances in which Members may be involuntarily disenrolled from a plan or an ACO.

In order for Members to stay enrolled with us, they have to keep their MassHealth eligibility. If they lose their MassHealth eligibility, they also lose their C3 MassHealth ACO membership. It is necessary that Members notify MassHealth about any life changes, such as new sources of income, moving, or changes to their family size. These changes can affect their MassHealth eligibility. It is also imperative that Members respond to MassHealth eligibility renewal requests annually. To learn more about eligibility, please see Section 2.1. *Eligibility Criteria*. To learn more about how we support MassHealth's renewal process, please see the *MassHealth Renewal (Redetermination) Process* Section below.

There may be other times when Members may need to be disenrolled from our plan, for instance Members may move out of the State, gain access to employer-sponsored insurance, or age into Medicare.

Our Participating FQHC or Affiliated Participating Provider may request the Member to be disenrolled. We strive to meet the health care needs of all Members. In the rare instance that a Member's enrollment/behavior seriously impairs the Participating FQHCs, Affiliated Participating Provider, or our ability to care for the Member or other Members, an involuntary disenrollment request

may be initiated. If it is determined that a formal involuntary disenrollment is justified, we will escalate the matter to MassHealth by submitting a formal involuntary disenrollment request. Participating FQHCs or Affiliated Participating Providers **may not** directly submit a formal involuntary disenrollment request to MassHealth. All such requests must come from our Organization. Participating FQHCs and Affiliated providers need to contact our Compliance Department (compliance@c3aco.org) to discuss the situation and receive the necessary forms and templates needed for the request. The initiation of the involuntary disenrollment process does not guarantee disenrollment from the Participating FQHC, Affiliated Participating Providers, or C3. Approval of such request is at the sole discretion of MassHealth. Our Members will be informed of any attempts to disenroll. For more information, please see COMP-046: *Involuntary Disenrollment* policy in Appendix A.

## MassHealth Renewal (Redetermination) Process

All ACO Members must complete the annual eligibility renewal with MassHealth in order to keep their MassHealth coverage and stay enrolled with us. For some Members, MassHealth may be able renew their eligibility automatically, while others will need to respond to MassHealth's request to renew. To learn more about MassHealth renewal process and ways to submit documents, please visit MassHealth website at: mass.gov/how-to/renew-your-coverage-for-masshealth-the-health-safety-net-or-the-childrens-medical-security.

Our Organization and our Participating FQHCs and Affiliated Participating Providers support our Members with the renewal process and ensure that they stay continuously enrolled with us. Our ongoing activities include but are not limited to:

- Ongoing communication and meetings with our FQHCs and Affiliated Participating Providers dedicated to the review of MassHealth enrollment and renewal rules, sharing best practices and workflows, and discussing upcoming issues.
- Distribution of Membership renewal files. We provide lists of Members who have been selected to renew MassHealth eligibility in tandem with a due date for the submission of such relevant documentation to MassHealth. These files are shared with each FQHC and Affiliated Participating Providers for processing. Processing may mean:
    - Contacting these Members and providing help with filling out forms.

- Sending voice and text messages on behalf of the FQHC or Affiliated Participating Provider and responding to the Members' request for help. These messages alert our Members that they are due to renew their MassHealth eligibility and that they can contact Navigators and Certified Counselors at their FQHC or Affiliated Participating Provider for help.
- Sending additional notices and communication.
- Other actions as necessary and appropriate.

To learn more about how we and our FQHCs and Affiliated Participating Providers support the continuation of enrollment and MassHealth's renewal process or to discuss the best options for you and Members, please contact enrollment@c3aco.org.

## 2.3 Member Information

### Member ID Card

Members have both a C3 Member ID card and a MassHealth Member ID card. Members are encouraged to keep both of their ID cards together. The MassHealth Identification number is the same as the identification number for C3 membership card.

Our Members receive their C3 Member ID card along with a welcome letter within 15 business days of their enrollment. Their C3 Member ID card shows that they are a patient of one of our Participating FQHCS or Affiliated Participating Providers as it includes the Health Center or Provider logo:


Pharmacies should use the following information when filing prescriptions for our Members:

**Member ID:** MassHealth ID number | **BIN:** 009555
**PCN:** MASSPROD | **Group:** MassHealth

## Member Handbook, Rights, Protections, Responsibilities, and Grievances

### Member Handbook

Our Member Handbook, along with the Covered Services List, contains essential information for Members and their Representatives. The handbook serves as a guide for understanding what it means to be a C3 Member. It lists Member rights, protections, and responsibilities, and provides information on medical, behavioral health and pharmacy benefits, including how to use them.

Our Member Handbook is available in English and Spanish. Interpreter services and alternate formats, including large print, are available upon request.

The handbook can be downloaded from our website: https://www.communitycarecooperative.org/members/masshealth/. Our Members are notified about availability of the Member Handbook and can request a copy by calling our Member Advocates at 866-676-9226 (TTY: 711).

### Member Rights

Our Members are guaranteed certain rights, and it is our job to uphold and protect these rights:

1. The right to clear information about C3, including in alternative formats if they have visual or other impairments.
2. The right to be treated with respect and dignity by staff at C3 and by any of their providers.
3. The right to privacy and confidentiality in all interactions with our Organization and Participating FQHCs and Affiliated Participating Providers unless we are otherwise required by law to share information.
4. The right to get information on available treatment options and alternatives, presented in a way that Members can understand. Information should be appropriate to your condition, culture, functional status, language needs, required modes of communication, and other accessibility needs.
5. The right to participate in all aspects of their care and to exercise all rights of appeal.
6. The right to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment, and to be appropriately informed and supported.

7. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with applicable federal law.
8. The right to ask for and receive any of their medical records we may have and be notified of the process for requesting amendments or corrections to their records.
9. The right to be notified of these rights and considerations at least annually, in a way that they can understand. Notifications should take into consideration their culture, functional status, language needs, and required modes of communication.
10. The right to ask for and receive information from us at least once per year.
11. The right to not be discriminated against because of their race, ethnicity, national origin, religion, sex, gender identity, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
12. The right to have all C3 options and rules fully explained. If a Member speaks a language other than English, they can ask for an interpreter when calling us. We provide free interpretation if our Members need it.
13. The right to receive help reading materials. If a Member reads a language other than English, they can have printed materials read aloud to them in their language by calling us.
14. If a Member has trouble seeing or reading, they can call us to have our materials read aloud.
15. The right to choose a plan and Provider that they qualify for at any time during their annual Plan Selection Period, including the right to disenroll from C3 and enroll in another MassHealth ACO, MCO, or the PCC Plan.
16. The right to receive timely information about changes to the benefits or programs offered by C3 and our providers, including PCPs, at least 30 days prior to the intended date of the change.

17. The right to designate a representative if a Member is unable to participate fully in treatment decisions, including the right to have translation services available to make information appropriately accessible to the Member or their representative.
18. The right to receive a copy of and to approve their Care Plan if any.
19. The right to expect timely, accessible, culturally, and linguistically competent, and evidence-based treatments.
20. The right to emergency care 24 hours a day, seven days a week from any hospital or other emergency care setting.
21. The right to decide who participates in the Member's care team, including family members, advocates, or other providers selected by the Member. We offer Native American Members the option to choose a Native American healthcare provider as a Primary Care Provider if the Native American Primary Care Provider has capacity to provide such services and permits Members to obtain such services regardless of affiliation to C3.
22. The right to receive a second opinion on a medical procedure.
23. The right to experience care as described in our ACO Contract with EOHHS, including receiving a Care Needs Screening and appropriate follow-up care.
24. The right to have advance directives explained and to establish them.
25. The right to file grievances and the right to access the EOHHS' Appeal processes. To learn more about our grievance process and our FQHC's and Affiliated Participating Providers' role in resolving grievances, please see Section 9 of this manual.
26. The right to be protected from liability for payment of any fees that are C3's obligation.
27. The right to freely exercise these rights.

We cannot deny services or punish Members for exercising their rights. Exercising their rights should not change their services and treatment. Our Participating FQHCs and Affiliated Participating Providers shall observe and comply with the Member Rights and protections.

## Member Protections

Our Organization is responsible for ensuring Members are not limited in receiving services they need.

We will make sure our participating PCPs make referrals to any provider, as appropriate, regardless of the provider's affiliation with our Organization. We do not restrict who our providers can refer to as long as they accept MassHealth Primary Care Clinician (PCC) plan. We maintain that we will:

- not impede access to or freedom of choice of providers;
- not reduce or impede access to medically necessary services;
- make sure Members can receive emergency services from any provider, including Emergency Services Program (ESP) or Mobil Crisis Intervention (MCI) providers, regardless of their affiliation with us.

We will not request that EOHHS disenroll Members from our Organization, Participating FQHCs, or Affiliated Participating Providers for reasons related to their health, such as changes in their health status, missing medical appointments, obtaining medical services, or declining a treatment. We also prohibit Participating FQHCs or Affiliated Participating Providers to request that EOHHS disenroll a Member for reasons related to the Member's health status.

However, we may ask EOHHS to disenroll Members if they continuously behave in a way that is so critically disruptive that we or their PCP cannot provide care for them or other Members of our Organization. We can only disenroll a Member if we receive permission from EOHHS first. Our Members will be informed of any attempts to do so. To learn more about involuntary disenrollment, please see Section 2.2 of this manual.

## Member Responsibilities

Our Members have certain responsibilities listed below:

- Be familiar with the Member Handbook to learn what is covered and what rules they need to follow to receive covered services and drugs.
- Tell their doctor and other healthcare providers that they are enrolled in our plan and present their C3 Member ID card and their MassHealth ID card every time they receive services or drugs.
- Refrain from sharing their Member ID cards. Letting other people use their Member ID cards to access services is considered fraud.

- Help their doctors and other healthcare providers give them the best care. This includes:
    - Calling their PCP or Care Manager when they need health care or within 48 hours of any emergency or out-of-network treatment.
    - Giving their providers the information they need.
    - Following the treatment plans and instructions that they and their providers agree on.
    - Making certain their doctors and other providers know about all the drugs they are taking, including prescription drugs and non-prescribed drugs, over-the-counter drugs, vitamins, and supplements.
    - Asking any questions that they have to ensure their doctors and other providers may explain things in a way they can understand.
    - Understanding the role of their PCP or Care Manager in providing care and arranging other healthcare services that they may need.
    - Following the Personal Care Plan that the Member has agreed to.
    - Understanding their benefits including knowing what is covered and not covered.
- Be considerate. We expect all our Members to respect the rights of other patients and of the professionals providing care to them. We also expect Members to act with respect in their providers' offices, hospitals, other facilities, and in their home when providers are visiting them.
- Pay what is owed. Members are responsible for these payments: The full cost of any services or drugs that are not covered by MassHealth. Refer to Section 4.1 for more information regarding MassHealth's appeal process.
- Notify us and MassHealth if they move.
- Notify us and MassHealth if their personal information changes such as telephone, marriage, additions to the family, eligibility, or other health insurance coverage.

**Member Grievance Process**

We provide a process for Members to bring their concerns to our Organization and FQHCs and Affiliated Participating Providers, and to have those concerns reviewed, investigated, and resolved within prescribed time limits.

Our Organization, FQHCs and Affiliated Participating Providers have established processes in place that enable us to promptly investigate, and resolve grievances filed

by our Members or their representatives. Our FQHCs and Affiliated Participating Providers are required to report grievances to our Organization. We encourage our FQHCs and Affiliated Participating Providers to report grievances by using our Member Grievance Report template that captures all necessary data elements. The report template can be found in Appendix B. Questions regarding our grievance process, training inquiries, and grievance reports should be submitted to grievances@c3aco.org.

The Compliance Officer provides oversight of our grievance process and ensures that all grievances are processed and resolved in accordance with policy guidelines and all contractual requirements. Additionally, the results of the grievance process are presented to the Compliance Committee on a quarterly basis at minimum, and opportunities for improvement are identified and implemented. This review includes sharing any patterns that emerge regarding grievance reasons or the site where a grievance was filed. Relevant information is also shared with other regulatory entities and Committees, such as the Patient and Family Advisory Council or our Quality Committee.

Our Organization's grievance reporting process creates opportunities to increase quality as a result of Member feedback. In addition, the tracking and trending of Member grievances may call attention to systems or individual performance problems and suggest quality improvement opportunities. For more information, please see COMP-011: *Member Protections – Grievances* policy in Appendix A.

# Section 3. General Participating FQHC and Affiliated Participating Provider Network Guidelines

## 3.1 What it Means to be in the C3 Network

Our Organization was founded in 2016 to play a leading role in transforming care for Medicaid beneficiaries as part of the Massachusetts Medicaid (MassHealth) 1115 waiver effective in 2018.

In that program, we are a Primary Care Accountable Care Organization (ACO) (sometimes called a "Model B"). We like the Primary Care ACO model, and similar models adopted by Centers for Medicare and Medicaid Services (CMS), because it puts us in close partnership with government payors.

In the MassHealth Primary Care ACO model, the Medicaid program contracts the network, pays the claims, and manages Member benefits, eligibility, and enrollment. This allows us to focus on impacting patient health and well-being through our providers. In addition, the Primary Care ACO shares savings and losses with MassHealth with respect to total cost of care performance.

Generally, Participating Providers – both Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers – are primary care organizations that share similar values and missions. FQHCs with independent Boards of Directors who participate in our primary risk contract(s) and meet other basic criteria may become our Corporate Members. This means they are "owners" of the company (to the extent that this concept applies in 501(c)(3) organizations) and they appoint individuals to our Board of Directors and Committees of the Board.

Non-member providers enjoy other benefits of participating with us, such as participation in risk contracts and other services and ventures we undertake and are not represented on the Board.

We are glad to welcome new Participating Providers. Providers interested in joining meet with senior leadership to learn about our Organization and discuss their interests. Management then makes a recommendation to the Board regarding participation. Once approved by the Board, and then MassHealth or another payor as appropriate, we collaborate with new providers to share

information and support implementation and ongoing collaborative work. This provider manual is one of the tools we use to perform this critical onboarding.

## 3.2 Components of Participation Agreement

All Participating FQHCs and Affiliated Participating Providers sign Participation Agreements that define their relationship to our Organization, including the terms of participation in risk contracts, and provide legally required protections for Member and patient information. These agreements differ slightly for Member FQHCs and Affiliated Participating Providers, but in the main they are identical. Our strong preference for simplicity and transparency in contracting drives us toward identical terms for similarly situated providers. We believe that exclusive deals and side agreements undermine the faith and trust required for effective, long-term collaboration.

One participation document is the Internal Financial Architecture (IFA). This document describes how we share risk in our risk contracts. Each risk contract has its own IFA. For some of our risk contracts, the document defines risk tiers such as high, medium, and low so that providers can elect the level of upside and downside risk, appropriate to their experience, balance sheet, and risk tolerance. For the EOHHS ACO contract, there is a single risk tier.

Another component of our Participation documents is our Delegation Agreement. Consistent with our overall Model of Care, which favors strengthening provider capabilities, we delegate the majority of population health and care management activities to providers that are able to staff and operate delegated programs successfully and take enough financial risk to be motivated to perform well.

## 3.3 Provider Network Management

### C3 and MassHealth Provider Data Requirements, Affiliations, and Terminations

Our Participating FQHCs and Affiliated Participating Providers are required to comply with a set of rules established by EOHHS related to provider eligibility, ACO participation, and FQHC and Affiliated Participating Provider data "maintenance" updates. This section describes MassHealth requirements for network management and the role of our Organization in the process.

Our Organization is required to submit PCP affiliation changes (for new and terminated PCPs) and maintenance updates to EOHHS on behalf of the Participating FQHCs and Affiliated Participating Providers. This process applies to the following maintenance changes:

- general maintenance, such as updating legal name, contact information, modifying panel size or age/gender panel information;
- assigning new MassHealth Provider ID/Service Location (PID/SL), such as opening new location or merging with another entity;
- closures which include location closures;
- site relocation;
- PCP linkages and affiliations with C3 which include affiliations and linkages of locations and individual practitioners.

EOHHS requires the submission of all requests as soon as the Participating FQHC or Affiliated Participating Provider becomes aware of changes:

- For PCP Affiliations (new affiliations and terminations) no later than 14 days prior to the effective date of the change.
- For site closures, openings or merges, MassHealth must be notified at least 60 days before these changes take place.

For new PCP affiliations, EOHHS requires submission of the Primary Care ACO Participating PCP Application. For any other maintenance changes, such as site closures, openings, or mergers, EOHHS requires additional documentation, including practice, PID/SL, and membership information, a copy of the Member notification, and other information.

Timely notifications are imperative as EOHHS does not backdate affiliations, and some of the changes may impact Member enrollment. MassHealth reconciles provider data on a quarterly basis. Our Participating FQHCs and Affiliated Participating Providers may be asked to support this process, as necessary.

## Provider Data Files for PCP and Other Network Changes

Our Organization is responsible for submitting new and terminated PCP affiliations and other maintenance updates to EOHHS. To comply with all requirements, our Participating FQHCs and Affiliated Participating Providers use Provider Data Files on our developed template to notify C3 about provider and FQHC and Affiliated Participating Provider changes. More information about the Provider Data File Template can be found in the Appendix B of this manual.

The Provider Data File on our Template, PCP ACO Affiliation form as appropriate, and/or information on any other maintenance changes as applicable are submitted to our dedicated e-mail: providerchange@c3aco.org (e-mails from centers contracted to us are secure and do not need to be encrypted).

The following should be considered when submitting provider files to our Organization:

- Files should be submitted bi-monthly on the 1st and 15th of each month.
- Files and forms do not need to be submitted if there are no provider changes. However, we ask our centers and Affiliated Participating Providers to notify us that there are no changes.
- Our Provider Team will send reminders and confirmation of receipt of each provider file and form submission.

In addition to the file submission, the MassHealth Primary Care ACO participating PCP Application is required for all new PCPs joining our Participating FQHCs and Affiliated Participating Providers. The application found in Appendix B should be submitted to C3 at least 14 days before the PCP's start date. All requests are subject to approval by EOHHS and must meet the requirements of the participating PCP contract. Untimely notifications may result in referral or payment processing issues. Providers who wish to enroll as participating ACO PCPs must be providers in MassHealth and must meet criteria listed in 130 CMR 450.119. If you are a new FQHC or Provider joining our ACO, EOHHS will also require this application to be completed for your center and your providers. This application is not required for PCP terminations.

For any other maintenance changes, such as site closures, openings, mergers, EOHHS requires additional documentation depending on the change type. EOHHS may require notifying impacted Members. Please contact us as soon as you are aware of these changes so we can collaborate with you and your leadership to provide proper notice and documentation to EOHHS.

Once the file, the forms, and other documentation, as applicable, are received, they will be processed by our team and updates will be submitted to MassHealth on your behalf. MassHealth usually processes PCP affiliation requests within 10 business days. Requests for other maintenance changes require longer processing. FQHCs and Affiliated Participating Provider contacts are notified about MassHealth approvals, denials, or requests for additional information.

## 3.4 Contractual Obligations

All Members must receive care that is timely, accessible, culturally, and linguistically competent. Medically necessary services should be delivered in a coordinated, person-centered manner, and in accordance with the Member's wishes, as necessary and appropriate.

For more information about clinical programs or expectations for general care delivery, please see Section 5 of this manual and CLA-041: *General Care Delivery* policy listed in Appendix A and the Primary Care Accountable Care Organization Participating Primary Care Provider Contract that your Organization signed with EOHHS.

### PCP Attribution and Empanelment

Members are attributed to our Participating FQHCs, Affiliated Participating Providers, and their sites (locations) based on a Member's self-selection or MassHealth auto-assignment. Our ACO membership enrollment data is received from MassHealth via daily and monthly files. Attribution information is generated in our population health platform which presents membership reports and other operational reporting.

Per 130 CMR 450.119, our Participating FQHCs and Affiliated Participating Providers must assign each Member to a PCP who meets criteria under the MassHealth regulations. This ongoing process of linking each patient to a care team and a PCP is called empanelment.

The importance of attribution and empanelment is critical as they impact accountability, quality of performance, relationships, care coordination, and are compliance driven. Our Organization supports Participating FQHCs and Affiliated Participating Providers to reach our annual empanelment target for the assigned patient population. To learn more about the empanelment logic implemented in our system or membership report, please contact your C3 Practice Transformation Manager.

### PCP Services and New Patients

Participating FQHCs and Affiliated Participating Providers are the principal source of primary care for Members who are enrolled in C3. Once Members are attributed (enrolled and assigned), the Participating FQHCs and Affiliated

Participating Providers are responsible for providing and coordinating their care, regardless of what the services needs are and regardless of whether those services can be provided inside of the primary care setting.

Member engagement is especially important. We encourage all FQHCs and Affiliated Participating Providers to contact new Members as soon as they are attributed to their location, in order to address patient care needs and meet contractual obligations found in their ACO Participating Primary Care Contract with EOHHS. This is especially important if the new Member does not have an established relationship with the FQHC or Affiliated Participating Provider.

Per the Contract with EOHHS, Participating FQHCs, and Affiliated Participating Providers must attempt to contact Members who are new to their practice within three weeks of enrollment in order to schedule an initial visit, unless the Member has previously been known to the center or provider and is already in the care of the Participating FQHC or Affiliated Participating Provider. Participating FQHCs and Affiliated Participating Providers should make their best effort to schedule the initial visit, when required, within four months of enrollment with the center or Affiliated Participating Provider. For new Members previously known to and currently in the care of the Participating PCP, no initial visit is required if the Participating PCP has performed a physical examination within the last 12 months or, in the case of a Member under age 21, within the period described in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule. Additionally, Participating FQHCs and Affiliated Participating Providers shall attempt to contact a Member who is pregnant within seven days of the Participating PCP learning of the Member's pregnancy to ensure that the Member is accessing prenatal care services.

To learn more about new Member (patient) orientation, visit requirements, and outreach, please review your Primary Care ACO Participating Primary Care Contract with EOHHS.

## Access to Care: Requirements for Medically Necessary Services, Appointments, and Urgent Care

Participating FQHCs and Affiliated Participating Providers must ensure all Members receive care that is timely. Providers who participate with MassHealth must meet certain requirements to make sure our Members do not have to wait too long for an appointment. Our Members can receive primary care at one of our participating FQHCs and Participating Affiliated Providers as well as utilize MassHealth, and Massachusetts Behavioral Health Partnership's (MBHP's) network of hospitals and specialists. To the extent that timely and medically

necessary services are not available through these networks, we may work on additional arrangements and notify MassHealth and MBHP.

Our FQHCs and Affiliated Participating Providers ensure that Members have access to primary or urgent care during extended hours to reduce avoidable inpatient admissions and emergency department visits. Participating FQHCs and Affiliated Participating Providers are responsible for publicizing their extended hours of care. To the extent that a Participating FQHC or Affiliated Participating Provider is unable to provide primary care or urgent care during extended hours, the Health Center or Provider must:

1. provide recommendations of alternative sources of care within C3's network or the broader MassHealth's and MBHP's network;
2. provide our Organization with a plan to reinstate primary care or urgent care during extended hours; this plan must be approved by our CMO.

Providers are required to provide medical and behavioral health care within the following timeframes:

- Emergency care, including emergency Behavioral Health Services that can be accessed at Community Behavioral Health Centers (CBHC) as they provide Mobile Crisis Intervention (MCI) onsite at specific locations and in the community:
    - An emergency medical provider must see a patient immediately after the patient asks for care in an emergency. For more information on CBHC and MCI services, including CBHC locations, please see Section 5 of this manual.
- Urgent care: PCP appointments for services that are not emergencies or routine services must be available for patients within 48 hours of their request.
- Episodic primary care (when a patient is sick, but it is not urgent): If a patient is sick, or if they have symptoms which do not require urgent care, a PCP must see the patient within 10 calendar days of the request for an appointment.
- Primary care (when a patient does not have symptoms): If a patient is not sick and does not have any symptoms, a PCP must see the patient within 45 days of the request for an appointment.

For children in the care and custody of the Department of Children and Families (DCF), providers are required to provide care within these periods:

- A child's PCP must offer a health screening appointment within seven (7) calendar days after the party responsible for a child or the DCF worker requests it.
- A child's PCP must also provide the child an appointment for a full medical exam within 30 calendar days after the responsible party or the DCF worker requests it. If a shorter period is required by the EPSDT services schedule, the PCP must meet the shorter period.

To ensure our Members have access to timely appointments and to avoid delays related to services provided to our Members, we created a "referral circle" which allows our Members to seek primary and specialty care at any of our Participating FQHCs and Affiliated Participating Providers without a referral. For more information about referrals and our referral circle, please see Section 4 of this manual.

For more information about clinical programs or expectations for general care delivery, please see Section 5 of this manual and CLA-041: *General Care Delivery* policy listed in Appendix A. You may also review the Primary Care Accountable Care Organization Participating Primary Care Provider Contract that your Organization signed with EOHHS.

## Medically-Necessary Medical and/or Diagnostic Equipment

C3 and each of its Participating FQHCs and Affiliated Participating Providers are responsible for ensuring that necessary medical and/or diagnostic equipment is accessible to Members. Medically necessary medical and diagnostic equipment includes, but is not limited to, the following:

- Examination tables that are accessible to people with physical disabilities
- Scales that are accessible to people in wheelchairs

Participating FQHCs and Affiliated Participating Providers are expected to maintain workflows to ensure Members are asked if special equipment is necessary for clinical appointments at the time the appointment is scheduled. To the extent that medical and/or diagnostic equipment is necessary, the FQHCs and Providers must schedule clinical visits at a time when such necessary medical and/or diagnostic equipment is available. Our Care Management team will work with MassHealth to ensure Member access to medical and/or diagnostic equipment outside of the FQHCs or Affiliated Participating Provider visit.

### Cultural and Linguistic Competency Requirements

C3 and our Participating FQHC and Affiliated Participating Provider are responsible for ensuring that care is delivered to Members in a culturally and linguistically competent manner. FQHCs and Affiliated Participating Providers must provide linguistic access to all Members either through employing medical interpreters or by having access to a language line with trained medical interpreters. FQHCs and Affiliated Participating Providers must make their best effort to employ medical interpreters in their most prevalent spoken language besides English. EOHHS has determined the current prevalent languages spoken by MassHealth Members are Spanish and English.

Our Organization reviews practices of our FQHCs and Affiliated Participating Providers related to cultural and linguistic competency requirements to ensure that appropriate services are available.

## 3.5 Other Provider and Pharmacy Networks

### MassHealth Specialty, Dental and Pharmacy Networks, MBHP Network, and Community Partners: Behavioral Health and LTSS

Our Members receive primary care services from any of our Participating FQHCs, Affiliated Participating Providers and their PCPs who are responsible for care coordination and referrals for specialty care.

Members also have access to a broad network of specialists and hospitals because we use MassHealth's PCC Plan, dental, and pharmacy networks for medical and dental care, and pharmacy benefits. To manage behavioral health benefits, we utilize the Massachusetts Behavioral Health Partnership (MBHP) network of providers. If providers are participating in the PCC Plan, MassHealth dental or pharmacy, or MBHP networks, they are de facto part of C3's network. Below is a brief list of provider resources:

- View the list of our Participating FQHCs and Affiliated Practices on our website:

  https://www.communitycarecooperative.org/members/find-a-providersf/

- To access the MassHealth Provider, Dental Directories, and Pharmacy Directories, access the following links:
  - MassHealth Specialty, Hospital, and Pharmacy Networks: masshealth.ehs.state.ma.us/providerdirectory/

- MassHealth Dental Provider Directory: provider.masshealth-dental.net/MH_Find_a_Provider#/home

- To find a behavioral health provider, visit the MBHP Directory: masspartnership.com/member/FindBHProvider.aspx
- To become a provider with MassHealth, a provider should call 800-841-2900 or visit their portal newmmis-portal.ehs.state.ma.us/EHSProviderPortal/providerLanding/providerLanding.jsf
- To become a provider with MBHP, providers should call 800-495-0086 or go online masspartnership.com/provider/GettingStarted.aspx

If a provider is not in one of these networks, MassHealth may still honor scheduled appointments, referrals, or prior authorizations during the Continuity of Care period for the ACO program and will pay for those services. For more information on Continuity of Care, please see Section 2.2 of this manual.

Please note, MassHealth does not contract with pharmacies outside of Massachusetts and will not cover medications obtained from an out-of-state pharmacy.

To learn more about covered services, utilization, or billing information, please see Section 4 of this manual.

**Community Partners: Behavioral Health and LTSS**

We partner with Community Partners (CPs) to coordinate and manage care for MassHealth ACO Members. CPs are organizations with experience delivering Behavioral Health (BH) and/or Long-Term Services and Supports (LTSS). Behavioral Health Community Partners (BH CPs) are community providers who provide comprehensive care management, including coordination of physical and behavioral health services. BH CPs bring clinical expertise in behavioral health to overall care coordination. LTSS CPs provide support to Members with complex needs. C3 provides CPs with a list of BH and LTSS eligible Members (patients) on a monthly basis. The list is compiled from a diagnostic and utilization-based algorithm as well as FQHCs, Affiliated Participating Providers, and CP referrals.

To learn more about the CP Program and care coordination, please see Section 5.4 of this manual.

## 3.6 Provider Trainings and Education

Our Organization provides trainings and additional supports to all Participating FQHCs and Affiliated Participating Providers to improve performance, implement best practices, increase participation in our activities, and expand awareness of processes and regulatory requirements. We offer:

- Trainings for care teams and other staff on an ongoing basis, such as forums, webinars, office hours, staff meetings.
- Monthly *News & Notes* which includes information on new initiatives, best practices, educational opportunities for care teams and other staff.
- ACO leadership and other monthly meetings with each FQHC and Affiliated Participating Provider which are used to increase awareness and provide other educational opportunities.

To receive more information about our meetings and training, please contact your designated Practice Transformation Manager.

## 3.7 Primary Care Sub-Cap Tier Requirement Attestation

Participating FQHCs and Affiliated Participating Providers have a single, unique Tier Designation for each unique, 10 -digit alpha-numeric Provider ID Site Location (PID/SL). We work closely with our FQHCs and Affiliated Participating Providers to assess, monitor, and close gaps related to the primary care requirements set forth in the EOHHS ACO Contract.

Our commitment to following the requirements is done through:

- The collection and maintenance of a copy of the Practice Tier Designation Attestation for our FQHCs and Affiliated Participating Providers signed by our Chief Executive Officer (CEO), and an authorized representative of the FQHCs and Affiliated Participating Providers, which in most cases is the CEO.
- Providing EOHHS with copies of the Practice Tier Designation Attestations upon request.

EOHHS requires an annual attestation for each PID/SL signed by the CEO or an authorized representative of the FQHC and Affiliated Participating Providers on the MassHealth Appendix D Tier Designation document. Our Organization ensures that all FQHCs and APPs achieve the Tier Designation they have attested to for each of their PID/SLs by the designated deadline on an annual

basis. The Practice Transformation Manager assigned to your FQHC or Affiliated Participating Provider ensures adherence to the Tier Designation for each PID/SL via a semi-annual review conducted with the FQHC and Affiliated Participating Provider's designated contact for Tier Attestation and Adherence.

# Section 4. Covered Services, Utilization, and Billing Information

## 4.1 MassHealth Coverage Guidance: Referrals and Prior Authorizations

### General Information, Covered Services, and Utilization

All MassHealth benefits are covered for our ACO Members based on their MassHealth coverage type. MassHealth benefits do not change when enrolling with C3 unless our Members' MassHealth coverage type changes. MassHealth limitations, prior authorizations, and referral rules apply. Referrals are not required for Participating Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers who are in our referral circle. To learn more about our referral circle, please see the *Referral Circle* Section below.

All requests for prior authorization, including benefit exceptions, should be submitted directly to MassHealth as it is the entity authorizing services for our Members. MassHealth will usually approve or deny the request within the following periods:

- transportation: Seven calendar days (or the number of days needed to avoid serious risk to your health or safety);
- private-duty nursing services: Fourteen calendar days;
- durable medical equipment: Fifteen calendar days;
- certain prescription medicine: 24 hours (please see Section 4.2 for more information about pharmacy coverage);
- all other services: Twenty-one calendar days.

To check on the status of a prior authorization, providers or Members should call MassHealth Customer Service. Members and providers should be notified by MassHealth if a service has been approved or denied. If MassHealth does not decide within the periods provided above or denies a service for a Member, their decision can be appealed with an impartial hearing officer of the Board of Hearings. For more details on the MassHealth Appeals process, visit https://www.mass.gov/how-to/how-to-appeal-a-masshealth-decision or call MassHealth. We encourage all providers to assist Members during an appeal process.

MassHealth may change its benefits, authorization, and referral requirements from time to time. All benefit, referral, and prior authorization changes are communicated with providers through Provider Bulletins and Transmittal Letters. Providers can directly subscribe to receive MassHealth Provider Bulletins and Transmittal Letters by e-mail at mass.gov/forms/email-notifications-for-masshealth-provider-bulletins-and-transmittal-letters. To view all Provider Bulletins or Transmittal Letters, please visit mass.gov/masshealth-provider-bulletins.

MassHealth has developed a Provider Page at mass.gov/masshealth-for-providers which includes important information on eligibility, coverage rules, claims submission, applicable forms, and directions on becoming a MassHealth provider. To read about dental coverage and rules, please refer to the MassHealth provider page for dental providers masshealth-dental.net/.

## Referral Circle

One of the benefits of being enrolled with Community Care Cooperative is participating in a "referral circle," which allows our Members to seek primary and specialty care at any of our Participating FQHCs and Affiliated Participating Providers without a referral. The referral circle reduces administrative paperwork and increases ease of access to care. All of the Member rights and protections set forth in Section 2.3 of this manual still apply to Members accessing care through the referral circle.

## Billing Information

All claims should be submitted to MassHealth. All services covered for our Members are processed by MassHealth, except for behavioral health services. Providers can review MassHealth's billing codes, rates, and billing procedures online mass.gov/lists/masshealth-provider-manuals. For more information about claims submission, please visit https://www.mass.gov/how-to/submit-claims. To learn more about behavioral health coverage, please see Section 4.3 of this manual.

## 4.2 MassHealth Pharmacy Information and Drug Coverage

### General Information, Covered Services, and Utilization

We use the MassHealth List of Covered Drugs and Over-the-Counter (OTC) medicine. The same MassHealth coverage rules apply, including limitations, prior authorization, and step therapy. All requests for prior authorizations, including benefit exceptions, should be submitted directly to MassHealth. Please visit the MassHealth Drug List at mhdl.pharmacy.services.conduent.com/MHDL/, to learn more about coverage rules. This website provides access to MassHealth authorization forms and other essential information.

MassHealth does not cover medications purchased at pharmacies located outside of Massachusetts even if it is an urgent situation. It is important for Members to obtain enough medication when traveling. To request a vacation override for our Members or for additional help with authorizations or prescription processing, please contact MassHealth's Drug Utilization Review Program or Pharmacy Help Desk (Conduent/POPS system) at the number provided in the Section below. You may also contact our Member Advocates for additional help. To learn more about MassHealth's decision periods and appeal process, please see Section 4.1 of this manual.

### Billing Information

All claims should be submitted to MassHealth. All services covered for our ACO Members are processed by MassHealth. For more information about claims submission, visit https://www.mass.gov/how-to/submit-claims.

Pharmacies should use the following information when filing prescriptions for our Members:

Member ID: MassHealth ID number
BIN: 009555
PCN: MASSPROD
Group: MassHealth

For help or additional pharmacy questions, providers can call the MassHealth Drug Utilization Review Program at 800-745-7318 or Pharmacy Help Desk (Conduent/POPS system) at 866-246-8503.

MassHealth copayments have been eliminated indefinitely. Additional rules and exceptions may apply. For more information on MassHealth coverage and copayments, please read MassHealth Provider Bulletins and Transmittal Letters.

## 4.3 MBHP Coverage Guidance for Behavioral Health Care and Programs

### General Information, Covered Services, and Utilization

Behavioral health care and services are managed by Massachusetts Behavioral Health Partnership (MBHP). MBHP offers high-quality, accessible, and culturally-appropriate health care to Members who are a part of our ACO. The MBHP provider network includes clinics, inpatient programs, outpatient services, Community Behavioral Health Centers (CBHC), and individual professional services such as social workers, psychologists, psychiatrists, and other providers who provide a range of behavioral health services to our Members.

Behavioral health services do not require referrals, but some services may require a prior authorization. All prior authorization requests for behavioral health services, including benefit exceptions, should be submitted to MBHP. Providers should use the MassHealth Eligibility Verification System (EVS) Virtual Gateway to verify Member eligibility prior to services.

If a service is denied or changed by MBHP, the Member will be notified about their appeal rights either with MBHP (1st level) or the Board of Hearings (2nd level). To learn more about the appeal process with MBHP, visit their website at https://www.masspartnership.com/mbhp/en/home/getting-started or call the Member Engagement Center at 800-495-0086.

Providers must register to access MBHP's benefit, prior authorization, claims and other information. To register, please visit MBHP website at https://providers.masspartnership.com/provider/RegistrationForm.aspx

For MBHP guidance, including information on benefits and prior authorizations, please access Provider Login for Service Authorizations at https://providers.masspartnership.com/provider/Login.aspx.

The MBHP Member Engagement Center has a toll-free number (800-495-0086) available 24/7 which manages both behavioral health provider and Member questions. Contact the MBHP Member Engagement Center for:

- Behavioral health provider enrollment and credentialing

- Behavioral health provider service authorizations and billing and claim submissions
- Issues with the Interactive Voice Registration (IVR) System
- To request a Health Needs Assessment for a Member, refer a Member to the Integrated Care Management Program, or for any questions about behavioral health services

MBHP has also compiled a list of resources for Members who may be experiencing homelessness, housing instability and/or housing discrimination. Some of the services that our Members have access to include detoxification services, crisis counseling, and long-term therapy. For additional resources, please visit their website at masspartnership.com which provides information on the following programs:

- Massachusetts Child Psychiatry Access Program (MCPAP)
    - A statewide program that offers primary care providers free telephone consultations with child psychiatrists and other BH education services.
    - Contact information: mcpap.com or email mcpap@carelon.com.
- Massachusetts Consultation Services for Treatment of Addiction and Pain (MCSTAP)
    - A statewide program that offers primary care providers free telephone consultation on safe prescribing practices and managing care for patients with chronic pain, substance use disorders, or both.
    - Contact information: mcstap.com or 833-PAIN-SUD (833-724-6783).
- Community Behavioral Health Centers (CBHC)
    - A statewide program that provides mental health and substance use disorder (SUD) crisis services and treatment
    - Referrals are NOT needed, and Members can utilize the CBHCs as an alternative to the Emergency Department
    - For CBHC locations, please visit https://www.mass.gov/cbhc-crisis-care?utm_source=google&utm_campaign=mbhp_phase2&utm_medium=english_cbhc&gad_source=1%22%20\t%20%22_blank
- The Massachusetts Behavioral Health Access website (MABHA)
    - A statewide program available to providers (medical and BH), individuals, and families to access mental health and substance use disorder services within one's community. The website allows providers, individuals, and

families the ability to search by Youth and Family Services, Substance Use Disorder Services, and Mental Health Services. MBHP has also compiled a list of resources for members who may be experiencing homelessness, housing instability and/or housing discrimination.

- Contact information: mabhaccess.com, 800-495-0086 or 617-790-4000.

For more information on how to become a MBHP-contracted provider or MBHP Directory, please see Section 3.5 of this manual. For information about our initiatives and collaboration with MBHP, Emergency Services Program (ESP) or Mobile Crisis Intervention (MCI), please see Section 5. 5 of this manual.

## Billing Information

Claims for behavioral health services should be submitted to MBHP. For MBHP guidance and billing information, please contact their Member Engagement Center at 800-495-0086 or register on their website at masspartnership.com/provider/RegistrationForm.aspx to obtain this information.

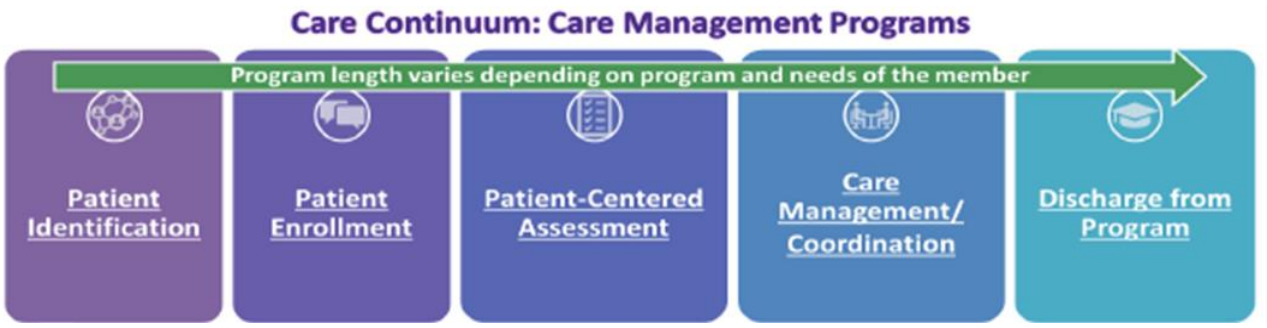
# Section 5. Services, Care Delivery and Management, and Clinical Programs

## 5.1 Overview of Care Management Services (Eligibility, Identification, and General Programming)

Our Organization's Care Management (CM) is a cohesive program that is designed to improve the quality of care and patient experience for high-risk, high-need Members. The goal of CM is to provide comprehensive psychosocial, behavioral, and medical support services to our Members. CM programming builds on existing capabilities and strengths at Health Centers and Affiliated Participating Providers to integrate CM into the primary care team. CM teams are embedded in the Federally Qualified Health Centers (FQHCs) and Affiliated Participating Provider's practices. The CM team collaborates with Members' primary care providers, acute and outpatient hospital facilities, CPs, and other external partners.

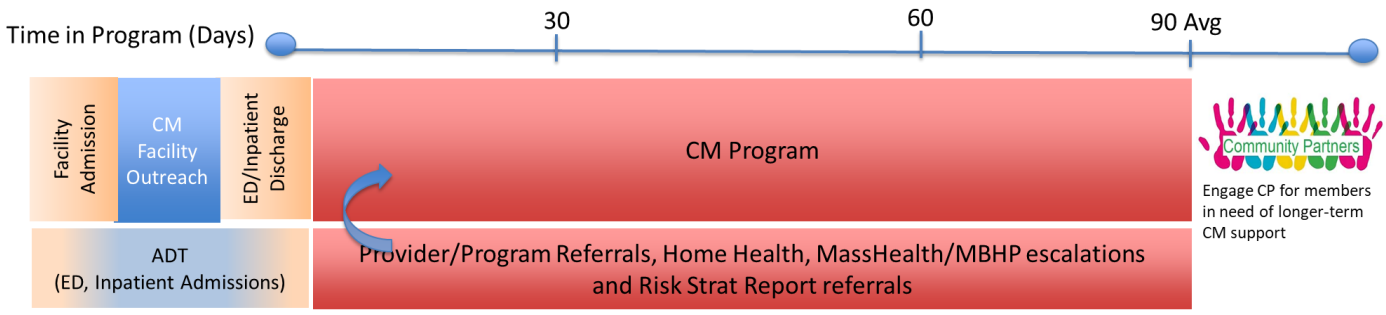
Predictive analytics are used to identify Members with elevated risks of behavioral health and physical health needs who would be most impacted if enrolled in a CM program. CM eligible Members are identified by inpatient and emergency department admission, discharge, and transfer (ADT) notifications (via live feeds), provider referrals, MassHealth, and other referral sources. By using motivational interviewing techniques to establish trust, Care Managers engage Members to enroll them in the program.

CM is a comprehensive approach to health and wellness designed to prioritize identifying and addressing Health Related Social Needs (HRSNs) while also addressing physical and behavioral health needs. Enrolled Members collaborate closely with a team of licensed professionals, Community Health Workers (CHWs), and where applicable, pharmacists. After a patient-centered assessment, the CM team collaborates with the Member to create a care plan. During care planning, the Member identifies their health goals, and the team collaborates with them to develop strategies and interventions to achieve those goals. When a Member meets the goals established in their care plan, they are discharged from the program. Members who need on-going CM may be referred to additional resources such as the Community Partners Program.




## Care Management Program Timeline for Members Admitted to a Facility

- Members who have been admitted to a facility and Members who stratify into the program based on our predictive analytic are the primary referral sources into CM. Other important referral sources include providers, home health agencies, MassHealth and MBHP escalations, and analytical reports of Members who are utilizing a high volume of services.
- Members are enrolled continuously with a Care Management team member for an average of 90-120 days.
- The CM team collaborates to optimize the expertise of each team member. The team assesses social needs that may prevent connecting Members to the primary care team and other supporting services. CHWs and licensed professionals are instrumental in establishing trust so Members will engage in the health care system.



## 5.2 Provider Referrals into Care Management

Our Participating FQHCs, Affiliated Participating Providers and their staff may consider Members for Care Management referrals based on high- or moderate-risk criteria.

**High-Risk Member Specifics:**

- Inpatient admission in the past 30 days or 2+ in the past 6 months
- Readmission in the past year
- 2+ ED visits in the past 6 months
- High-risk for inpatient/ED admits in the next 6 months
- Significant decline in functional status/need for increased support

**Moderate-Risk Member Specifics:**

- High-risk chronic disease such as Asthma, COPD, CAD, CHF, Diabetes, Hypertension, BH Conditions or Substance Use
- > 8 prescriptions (not including DME needs)
- Inadequate follow-up with PCP and/or not following care plan or specialty care coordination
- Significant physical, mental, learning, or other disability impacting reasons for referral
- Health-Related Social Needs
- Interpersonal violence
- Other (PCP specific concerns.

Providers are encouraged to refer any Member cases to CM to conduct a review of the Risk Strat Criteria. There may be instances when a provider feels a Member "may benefit from" Care Management services yet the Member is not on an Arcadia "High Risk List." Such cases should be discussed between the Provider, Care Management Staff, and/or in a clinical "round" session.

CM Teams are strongly encouraged to include providers, especially the PCP, in Care Plan reviews and other CM activities as appropriate.

## 5.3 Care Needs Screening Process

Care Needs Screening (CNS) is a MassHealth contractual requirement. Our Members are offered the opportunity to complete a Care Needs Screen called "How's Your Health" (HYH) when they are enrolled with C3. We provide information on how to access the CNS in both the our Member Welcome Packet and the Member Handbook, as well as on our website at C3aco.org/mycareneeds. The CNS can also be completed by calling 866-676-9226 (TTY: 711).

We make the best efforts to ensure that all newly enrolled Members complete an initial CNS tool within 90 days of their effective date of enrollment. The HYH tool aligns with MassHealth's contractual requirements to capture demographics, health history and perceived health status, risk factors, special health care needs, and requirement for cultural, linguistic, or disability access. A separate screening tool is used to determine the care needs of children and adolescents.

The youth CNS screening tool screens youth who may need behavioral health services, LTSS, assistance in activities of daily living (ADLs), or have health-related social needs and/or affiliations with other State agencies. Both the youth and adult CNS are MassHealth approved. The CNS is available to Members in multiple languages and formats including electronically on our website, print and telephone. Screening is conducted with the consent of the Member and includes disclosures of how the information is used.

Members can complete the CNS in 3 ways:

1. Online utilizing the link provided in the welcome mailing: communitycarecooperative.org/mycareneeds
2. Over the phone with a Member Advocate: 866-676-9226 (TTY: 711)
3. Via hard copy by requesting that a paper version be sent to the Member's address

Based on a Member's response to the CNS, the following action may be taken:

**Action 1:**

- Members who complete the survey are given an opportunity to have their care needs addressed via either Care Coordination efforts at the Health Center level and/or are referred to a Care Management Program.

- Each FQHC or Affiliated Participating Provider is notified via a monthly report shared by C3.
- FQHCs or Affiliated Participating Providers have an identified process to receive referrals from Member services.

**Action 2 (Time-Sensitive):**

- There are two safety questions on the CNS that require a prompt response:
  - Do you have any concerns about the following: "Violence or Abuse?"
  - Any extreme feelings of sadness or thoughts of harming yourself?
- If a Member answers *YES* to either or both questions, C3 is alerted immediately and has a process to connect with the Member's FQHC or Affiliated Participating Provider to have an immediate behavioral health follow-up.

## 5.4 Care Coordination with Community Partners: LTSS and Behavioral Health Programs

The Community Partners (CP) Program is a MassHealth-funded program that launched in July of 2018. Community Partners (CPs) are organizations with experience delivering Behavioral Health (BH) or Long-Term Services and Supports (LTSS) that partner with ACOs to coordinate and manage care for certain patients. The goal of the program is to provide Members with care coordination and Care Management services to promote integration with primary care, and to reduce the total cost of care, utilization, and readmissions.

Behavioral Health Community Partners (BH CPs) are community providers who provide comprehensive care management, including coordination of physical and behavioral health services. BH CPs bring clinical expertise in behavioral health into the process of overall care coordination. Long-Term Services and Supports Community Partners (LTSS CPs) coordinate between physical health and LTSS systems. LTSS CPs collaborate with our Organization to coordinate Members' medical and social needs.

Every month, Members who are eligible for the CP Program are identified by our analytics teams using an algorithm based on diagnostic criteria and utilization. Members are also identified by Participating FQHCs and Affiliated Participating Providers, Care Management, or by CPs. Regardless of the referral source, our Organization is responsible for assigning these Members directly to the CPs. The assigned CP is determined by Members' geography.

- BH CP Eligibility: Individuals ages 18 to 63 with a BH diagnosis including SUD and at least one of the following:
    - In the last 18 months have had 3+ ED visits, 2+ detox, 2+ IP stays, select medical comorbidities, DMH enrollment, and/or high LTSS utilization.
- LTSS CP Eligibility: Individuals ages 3 to 64 with brain injury or cognitive impairments, physical disabilities/mobility impairments, Alzheimer's Disease, and patients with intellectual or developmental disabilities including autism. These members often have several LTSS needs which include:
    - PCA, Home Health, Hospice, Adult Foster Care, DME, to name five.
- BH CPs and LTSS CPs are responsible for completing a Patient-Centered Assessment and Care Plan that guides the services that patients receive. The BH CPs and LTSS CPs have 153 days to complete the Patient-Centered Assessment and Care Plan. The BH CPs and LTSS CPs share both the assessment and care plan with the member's identified PCP and care team.

## 5.5 Behavioral Health Programs

The Massachusetts Behavioral Health Partnership (MBHP) manages the MassHealth behavioral health benefit plan for our ACO Members. Our Care Management leadership team meets with MBHP's management team on an ongoing basis to discuss operations, quality improvement strategies, and Member Operation initiatives. C3's and MBHP's clinical team conduct case reviews of all Members in the Emergency Department (ED) experiencing greater than 24 hours of wait time for placement to a higher level of care, as well as ED high utilizers, to determine required referrals and address barriers to members obtaining services. Additionally, there is ongoing work to address opportunities to strengthen existing relationships with MBHP, Community Partners (CPs), Emergency Service Programs (ESPs), and Children's Behavioral Health Initiative (CBHI) providers. This collaboration will address the issue of the aforementioned overextended wait time for Members in the ED and break down care coordination silos when Members are receiving services from multiple community providers.

### Community Behavioral Health Centers (CBHC), Emergency Services Program (ESP), and Mobile Crisis Intervention (MCI) Services

Emergency Services Program (ESP) provides behavioral health crisis assessment, intervention, and stabilization services (24/7, 365 days per year) to individuals of all ages with mental health, substance use disorder, and/or co-occurring conditions who are experiencing a behavioral health crisis. ESP services are now

included within the Community Behavioral Health Centers (CBHC). CBHCs provide an alternative to ED visits for individuals seeking behavioral health services. CBHCs provide the following services:

- onsite face-to-face therapeutic response, including short-term, purposeful counseling;
- psychiatric consultation and urgent psychopharmacology intervention;
- referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care;
- safety plans developed in collaboration with patient's behavioral health providers and/or supports to expedite a Member-focused disposition based on the experience gained from past treatment intervention.

There are approximately 30 MBHP-managed catchment areas covering every city and town, which includes CBHC locations.

A full statewide directory of CBHCs can be accessed on https://www.mass.gov/info-details/find-a-cbhc. Carelon (the Parent Company of MBHP) created a patient and family facing educational video so that members understand how and when to access ESP services. The following link can be shared with members to provide education on accessing ESP services: vimeo.com/473975546/49a5bd33d9.

- Individuals can obtain their local ESP Toll Free Number by entering their zip code at 877-382-1609.
- Available in English and Spanish.

Mobile Crisis Intervention (MCI) is also provided within the CBHCs. MCI provides a short-term service that is a mobile, onsite, face-to-face therapeutic response to youth (ages 0-20) experiencing a behavioral health crisis. MCI provides crisis assessment, intervention, stabilization, and care coordination. This service is provided 24 hours a day, 7 days a week.

ESP services are provided to adults primarily through the ESP's Adult Mobile Crisis Intervention services. ESPs will "mobilize" or travel to an individual's private home and other community locations, such as schools and residential programs, to provide ESP services. Mobile Crisis Intervention is provided at any location in the community, including private homes, from 7 a.m. to 8 p.m. Outside of those hours, Adult Mobile Crisis Intervention services are provided in residential programs, and other supervised settings.

For more information about MBHP's behavioral health services and programs, please see Section 4.3 of this manual.

## 5.6 Other Programs

### Wellness Initiatives and Programs

Wellness and health education activities are delegated to our Participating Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers to provide Members with culturally and linguistically appropriate services and programs. In addition, care management includes Member education on activities and behavior changes that promote wellness.

Each Participating FQHC and Affiliated Participating Provider conducts a community needs assessment. Assessments are used to identify the predominant health needs and cultural and linguistic requirements of the community. Based on this, they develop programs to meet the needs of their community. Program examples include the following:

- Targeted nutrition programs for pregnant women, children, and Members with chronic conditions such as obesity, diabetes, heart disease, and HIV, to cite four examples. These programs include classes, group visits, and individual counseling by licensed nutritionists.
- General health education for new immigrants to understand how to access necessary programs and services.
- Chronic disease self-management programs to educate and support patients living with conditions such as diabetes, heart disease, chronic pain, and substance use disorders.
- Educational programs focused on the prevention and treatment of substance use disorders in addition to the multi-disciplinary intervention associated with Medication Assistance Treatment (MAT) and Office-Based Opioid Treatment (OBOT) programs provided by most Participating FQHCs and our Affiliated Participating Providers.
- All visits begin with screening for tobacco use and where needed include smoking cessation counseling provided by nurses and providers.
- Nurses schedule follow-up visits or are available via warm handoffs to provide patient education about chronic diseases and self-management.
- Patients with chronic diseases are also educated on signs and symptoms of complications of chronic diseases in scheduled nurse visits.

- Pediatric visits include screening and early detection of children's mental illness and the education of parents by the pediatrician with a warm handoff to a behavioral health provider available.
- Adult visits may include a Screening Brief Intervention and Referral to Treatment (SBIRT) as well as education on the prevention and treatment of substance use disorders.

The primary care team identifies the need for Member education based on the Member's medical condition, lifestyle and social information, and Member's preferences and health goals.

Electronic Health Record (EHR) systems integrate Member education into Member care through having literature and resources available in the Member's EHR chart, or in our population health platform. Materials are available in multiple languages, such as (English and Spanish). Additional formats and interpreter services are available based on the Member needs and request. Where clinical staff do not speak the Member's preferred language, an on-site or telephonic medical interpreter participates in the interaction.

The primary care team is then able to review the educational materials printed from the EHR system with the Member during the visit.

- If a Member is not able to access educational materials in the EHR system, clinicians can provide pre-printed materials which are available at the FQHC of Affiliated Participating Provider's practice.
- The primary care team should refer Members to additional resources such as wellness and health education classes and programs within and outside of the Health Center or Affiliated Participating Provider's practice to promote healthy behavior and lifestyle.
- Additional information and resources are also available on our Organization and our FQHCs' or Affiliated Participating Providers' websites as well as in our population health platform.

Wellness programs developed by Participating FQHCs and Affiliated Participating Providers must comply with applicable Federal and State laws and regulations including those designed to protect privacy and confidentiality.

In addition to wellness initiatives provided directly by our FQHCs and Affiliated Participating Providers, our Organization supports practices to develop referral relationships to meet Member needs for culturally competent wellness services not available at the practice. Examples include:

- Childbirth education
- Smoking cessation
- Fitness programs and memberships in organizations such as local YMCAs
- Support for substance use disorders

We provide care management programs for Members both directly and through delegation agreements that support them with wellness and health education. The interdisciplinary teams for these programs are trained in the provision of wellness education. The nurse care managers collaborate with Members to develop self-management goals as part of their care plan. During the time that the Member is in the program, a key focus is providing education on how to achieve goals around self-management and wellness. This education is provided by Community Health Workers (CHWs), dieticians, clinical pharmacists, and pharmacy technicians. CHWs are crucial to the education model because they are specifically trained in wellness and patient education. In addition, the population health management platform supporting these programs provides access to written health education materials that can be printed out in the appropriate language for program Members.

For more information, please see CLA-024: *Wellness Initiatives and Education* policy in Appendix A.

## Nurse Advice Line

Our Organization contracts with the vendor, Call 4 Health, for the provision of a Clinical Advice and Support Line available to Members 24 hours a day, 7 days a week, through a toll-free number: 800-769-8969 (TTY: 711). This service is also an option for after-hours coverage and Emergency Department visit diversions when a Member's Participating FQHC or Affiliated Participating Provider's office is closed. Members are informed about the line and educated on its use at a minimum through the Member Handbook. Information about the Nurse Advice Line is also available on our website.

The telephonic nursing line is staffed by Massachusetts licensed registered nurses and health services representatives trained in nurse triage. They provide general health information to Members, answer general health and wellness related questions, and provide medical triage to assist Members in determining the most appropriate level of care for their illness or condition. The clinicians use documented, evidence-based protocols for determining the caller's acuity and need for emergency, urgent, or elective follow-up care. Protocols include the Schmitt-Thompson telephone triage protocols, and the clinical protocols

established and approved by Call 4 Health and C3. They advise the caller to address clinical needs at home, go to the Emergency Room or an urgent care center, contact the on-call provider, or contact the Member's FQHC or Affiliated Participating Provider for an appointment, or for all matters not addressed by the advice line. Members may also be instructed to call 911.

The Clinical Advice and Support Line utilizes telephonic language interpretation services and when possible, bilingual nursing staff, for callers who indicate the need for interpretation. Services are also available for deaf and hard-of-hearing callers via MassRelay services (TTY:711). These nurses are trained to access our population health platform to review the Member's medical history, access care management notes and primary care provider information. Each call is recorded and saved along with a complete written assessment.

FQHCs and Affiliated Participating Providers have established workflows to ensure Clinical Advice staff can provide Members with information such as a list of our providers, contact information and hours of operation. The FQHC or Affiliated Participating Provider has established a point of contact who is notified electronically after each recorded call. The Nurse Advice Line will, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security standards, email and provide a confidential HIPAA compliant patient (Member) encounter report to the relevant center. The Clinical Advice Line is not to be considered as a replacement for in-person medical services or physician care and does not include the diagnosis or treatment of caller ailments.

For more information, please see COMP-033: *Clinical Advice and Support Line* policy in Appendix A.

## Health Related Social Needs (HRSNs) and the Social Health Program

We recognize that social drivers of health, such as food insecurity and housing instability, play a leading role in our Members' health and well-being. Each FQHC and Affiliated Participating Provider have established workflows to screen our Members for health-related social needs at least once per year, according to the MassHealth Quality and Equity Incentive Program. We provide a variety of support to staff conducting these screenings and referring members to relevant community resources, including:

- Providing access to the online FindHelp community resource and referral platform to identify community organizations with capacity to support members' needs: https://c3staff.findhelp.com/. Training resources for this platform are available.

- Offering additional training on skills and strategies such as motivational interviewing and trauma informed care, as well as timely program and policy updates related to food insecurity, housing, legal, and other topics relevant to social drivers of health. Live training sessions and recordings of previous trainings are available upon request.

In addition, MassHealth Members may be eligible for one of the following programs:

**Community Support Program (CSP)***

Specialized CSP services provide targeted services to Members based on their unique situation. Specialized CSP includes:

- Community Support Program for Homeless Individuals (CSP-HI) – a Specialized CSP service to address the health-related social needs of Members who are experiencing homelessness and are frequent users of MassHealth's acute health services or Members who are experiencing chronic homelessness. CSP-HI services include pre-tenancy support in transitioning into housing, and tenancy sustaining support.
- Community Support Program Tenancy Preservation Program (CSP-TPP) – a Specialized CSP service to address the health-related social needs of member who are at risk of homelessness and facing eviction because of behavior related to a disability. CSP-TPP partners with the Member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services to address the underlying issues causing the lease violation.
- Community Support Program for Individuals with Justice Involvement (CSPJI) – a Specialized CSP service to address the health-related social needs of Members with justice involvement who have a barrier to accessing or consistently use medical and behavioral health services. CSP-JI includes behavioral health and community tenure sustainment support.

**Social Health Programs***

Our Organization offers a Social Health nutrition and housing program to address root causes of poor health such as food insecurity, housing instability, and homelessness for certain Members who meet the health needs-based criteria and social risk factor. The goal of this program is to improve access to healthy food and stable housing for Members and enable them to live healthier lives without costly medical care.

We manage partnerships with contracted social services organizations across Massachusetts, investing directly in the communities where Members live and

work. Our Social Health programs are available to each of our FQHC and Affiliated Participating Providers, with a focus on referring Members enrolled in our Care Management program and other populations with complex behavioral and physical health needs or high ED utilization who meet the MassHealth eligibility criteria.

**Nutrition Programs:** For enrolled Members who are experiencing food insecurity, our partners assure that eligible Members have the necessary assistance and navigation for local food programs and SNAP, as well as providing healthy groceries and home-delivered meals, as well as improving healthy habits with nutrition education classes, kitchen items and transportation to the grocery store.

**Housing Programs:** For Members with housing instability, our partners provide navigation to housing benefits programs, assistance with housing search and placement for homeless members, and support for tenancy preservation and eviction prevention. Through the program, we can also support home modifications such as purchasing ramps, air conditioners, and other items to make homes healthier.

** Please note anticipated changes on 1/1/25 to the program guidelines for the Social Health Programs. The programs currently called Community Support Program (CSP) and the Flexible Services Program will shift to the Health Related Social Needs (HRSN) program, with updates to Member eligibility and service availability.*

## Telehealth & Digital Health

We encourage all of our Participating FQHCs and Affiliated Participating Providers to leverage telehealth and other digital health tools as a means to provide patient-centered access to care. Our Organization is available to support Participating FQHC and APP teams in this work by sharing strategies and best practices, developing tools and resources, and assisting in strategic planning efforts.

For more information about telehealth and digital health, please contact your C3 Practice Transformation Manager.

# Section 6. Quality

## 6.1 Quality Program Overview and Approach

Our Organization has a quality program whose purpose is to ensure that Members receive quality health care. We define quality health care as "care that is safe, effective, patient-centered, timely, efficient, and equitable [1]."

We use a quality management approach consisting of three universal processes of quality management:

- **Quality Planning:** Quality plans, with associated targets, are developed annually and revised mid-year.
- **Quality Control:** Performance is tracked throughout the year, and an indication of undesired change triggers improvement action.
- **Quality Improvement:** the tools of improvement are deployed in testing change ideas and scaling what works.

[1] Committee on Quality of Health Care in America; Institute of Medicine (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press. Chapter 1.

## 6.2 Quality Measures, Targets, and Quality Score

### Quality Measures

We use the MassHealth ACO quality measure slate, which contains 13 clinical quality measures and two Member experience measures. The 17 total measures are designed to advance the quality of care in four domains of quality:

- Preventive and Pediatric Care
- Care Coordination / Care for Chronic & Acute Conditions
- Member Experience

Most ACO clinical quality measures were developed and are updated annually by national measure stewards, such as the National Committee for Quality Assurance (NCQA). A subset of measures was innovated by MassHealth for the ACO program (EOHHS). The Member Experience Survey is based on the Primary Care CAHPS survey (Consumer Assessment of Healthcare Providers and Systems). It is administered by MassHealth in multiple languages and modalities once per year.

Data sources for each measure are designated by MassHealth and adopted by our organization. Measures are calculated using either claims data alone, or a combination of clinical (EHR) and claims: hybrid data.

We provide measure specifications and updates to our Participating Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers regularly.

| Domain | Quality Measure | Measure Steward | Data Source |
|---|---|---|---|
| Preventive and Pediatric Care | Developmental Screening- First Three Years of Life | NQCA | Claims/Hybrid |
| | Immunizations for Adolescents | NCQA | Hybrid |
| | Childhood Immunization Status | NCQA | Hybrid |
| | Prenatal Care and Postpartum Care | NCQA | Hybrid |
| | Topical Fluoride for Children | ADA DQA | Claims |
| | Screening for Depression and Follow-Up Plan | CMS | Hybrid |
| Care Coordination/ Care for Acute and Chronic Conditions | Follow-Up After Emergency Department Visit for Mental Illness | NCQA | Claims |
| | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days) | NCQA | Claims |
| | Follow-Up After Hospitalization for Mental Illness | NCQA | Claims |
| | Asthma Medication Ratio | NCQA | Claims |

| Domain | Quality Measure | Measure Steward | Data Source |
|---|---|---|---|
| Care Coordination/ Care for Acute and Chronic Conditions | Controlling High Blood Pressure | NCQA | Hybrid |
| | Glycemic Status Assessment for Patients with Diabetes | NCQA | Hybrid |
| | Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment | NCQA | Claims |
| Member Experience Survey | Communication (Adult & Child) | AHRQ | Survey |
| | Knowledge of Patient (Adult & Child) | AHRQ | Survey |
| | Integration of Care (Adult & Child) | AHRQ | Survey |
| | Willingness to Recommend | AHRQ | Survey |

## Quality Measure Targets

MassHealth sets a low benchmark and a high benchmark for each quality measure. These benchmarks are set for the duration of the contract. MassHealth additionally provides an improvement target for the expected year-over-year improvement on each measure.

## Quality Score

MassHealth calculates official measure performance and a quality score annually. The quality score is a numeric calculation of individual measure performance on a scale of 0 to 100%. Each measure is scored based on meeting the MassHealth low, high, and improvement targets. Measures are then bundled into the four quality measure domains listed above, which each have different weights in the quality score. MassHealth uses the quality score to

determine contract performance on quality and calculate the quality withhold (please see Section 6.6 of this manual).

## 6.3 Quality Improvement Initiatives

At the beginning of each calendar year, we set a MassHealth quality score target and targets for each measure. These targets represent our best avenue to the desired quality score and population health outcomes. Alongside participating FQHCs, and our Affiliated Participating Providers, we adopt annual quality improvement plans to meet the goals.

Our Participating FQHCs and Affiliated Participating Providers may adopt a quality improvement framework that best fits their structure and needs.

## 6.4 Compliance with Regulatory Requirements

### Annual Quality Chart Review

Participation in the annual quality chart review is a regulatory requirement for all participating FQHCs and Affiliated Participating Providers in the MassHealth ACO contract. The annual chart review is the process of extracting medical records from EHR's to calculate official quality performance for hybrid measures. We partner with FQHCs to obtain and review records. We will coordinate the chart review process and ask FQHC and APP staff to assist as needed (e.g. obtaining access to EHR). C3 is responsible for submitting the findings to MassHealth. MassHealth calculates official quality measure performance annually based on the findings.

### External Quality Review (EQR)

The External Quality Review (EQR) is a CMS requirement that C3 completes every three years on behalf of Participating FQHCs and Affiliated Participating Providers. Our Organization aggregates information on quality, timeliness, and access to the health care services for ACO members using standard templates. MassHealth, via an External Quality Review Organization (EQRO), completes an audit of the documentation.

## 6.5 Performance Evaluation and Reporting

Official quality measure performance is calculated by MassHealth annually after the conclusion of the annual chart review. We provide real-time performance evaluation tools and reports to support quality gap identification, patient outreach, and trend monitoring. Our population health platform aggregates data from EHR's daily and monthly from claims file we receive from MassHealth and MBHP. Additionally, the Quality Program provides monthly a Quality Dashboard to FQHCs and Affiliated Participating Providers.

## 6.6 Impact of Quality on Finances

Quality performance has an impact on FQHC and Affiliated Participating Provider finances in the MassHealth ACO. A good quality score can offset a portion of a loss in a contract year in which the total cost of care exceeds the budget. A low-quality score can result in a negative adjustment to earned shared savings. This is a system of checks and balances to ensure that quality care does not come at the expense of reducing the cost of care.

# Section 7. Health Equity

## 7.1 Health Equity Incentive Program

### Health Equity Score

The MassHealth Health Equity Incentive Program (HEIP) utilizes the health equity score to evaluate our performance on the health equity measure slate. The slate has three domains with nine measures. Each measure is weighted, with a combined score of up to 100 percentage points. At the end of the year our health equity score represents the percentage of points we achieved out of the allowable 100 points.

**HEIP Measure Slate: Domain 1 - Demographic and Health-Related Social Needs Data**

| Subdomain | Metric | Weight (x/100) |
|---|---|---|
| **Domain 1. Demographic and Health-Related Social Needs Data** | | **25** |
| Demographic Data Collection | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness | 10 |
| Health-Related Social Needs Screening | Screening for Social Drivers of Health (CMS): Preparing for Reporting Beginning in PY2 | 15 |

The first domain is Demographic and Health-Related Social Needs Data, with a weight of 25 percentage points. This evaluates our collection of data on race, ethnicity, language, disability, sexual orientation, gender identity, and health-related social needs screening.

**HEIP Measure Slate: Domain 2 - Equitable Access and Quality**

| Subdomain | Metric | Weight (x/100) |
|---|---|---|
| **Domain 2. Equitable Access and Quality** | | **50** |
| Equity Reporting | Stratified Reporting of Quality Data | 10 |
| Equity Improvement | Performance Improvement Projects | 10 |
| Access | Meaningful Access to Healthcare Services for Persons with a Primary Language Other Than English | 10 |
| | Disability Competencies | 10 |
| | Accommodation Needs Met | 10 |

The second domain is Equitable Access and Quality, which consists of five measures with a weight of 50 percentage points. This evaluates how we utilize data collection from Domain 1 to provide accommodations for language services and disabilities, as well as to identify and address disparities in outcomes.

**HEIP Measure Slate: Domain 3 - Capacity and Collaboration**

| Subdomain | Metric | Weight (x/100) |
|---|---|---|
| **Domain 3. Capacity and Collaboration** | | **25** |
| Capacity | Achievement of Accreditation Readiness | 15 |
| | Patient Experience: Cultural Competency | 10 |

The third domain is Capacity and Collaboration. This evaluates our progress towards obtaining health equity accreditation from the National Committee for Quality Assurance (NCQA) and the feedback we receive from members about their experience with our care. It has a weight of 25 percentage points.

## 7.2 Delegation Agreements

Delegation agreements are a MassHealth requirement providing oversight of all health equity-related functions that Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers perform on behalf of the ACO. The delegation agreement lists the functions and describes the means of evaluating the execution of those functions. In connection with delegation agreements, we established FQHC and Affiliated Participating Provider Health Equity Scores, using a design similar to the MassHealth HEIP health equity scores.

## Delegated Functions

| Domain | Metric | Weight (%) |
|---|---|---|
| **Direct data collection** | Race | **30** |
| | Ethnicity | |
| | Language | |
| | Sex at birth | |
| | Gender identity | |
| | Sexual Orientation | |
| | Disability | |
| | Pronouns | |
| **Data collection practices and policies** | Non-stigmatizing practices for gender identity data collection | **15** |
| | Sharing pronouns with member-facing staff | |
| | Non-stigmatizing practices for sexual orientation data collection | |
| | Notification of privacy protections | |
| **Language services policies and practices** | Translator competence | **10** |
| | Timeliness of translations | |
| | Oral interpretation | |
| | Evaluation of the quality of translation | |
| | Share individual language data with practitioners | |
| | Provide practitioners with language assistance resources | |
| | Make interpretation services available to practitioners | |
| **Practitioner race/ethnicity and language** | Collect practitioner languages | **10** |
| | Collect practitioner race/ethnicity | |
| **Implementing interventions to address healthcare inequities** | Implement an intervention to address a healthcare inequity | **15** |
| | Train all providers and staff in racial equity and disability competencies | |
| **Screening for disability and language needs** | Screen for disability accommodations needs | **10** |
| | Screen for language services needs | |
| **Record service provision for disability and language needs** | Record the provision of services to meet disability accommodation needs and language services. | **10** |

We categorized the delegated functions into seven (7) domains.

**What Data is Collected and to What Extent?**

The data collection domain evaluates both the demographic categories for which the FQHCs and Affiliated Participating Providers collect data and the extent of data completeness. In 2024, there are no thresholds for data completeness, as this is a pay-for-reporting year. However, 2025 is a pay-for-performance year, and FQHCs and Affiliated Participating Providers are expected to achieve completeness rates of at least 50% for race, ethnicity, and language, and 30% for disability, sexual orientation, and gender identity. In 2026, the thresholds will increase to 80% and 50%, and to 80% and 80% in 2027.

**Data Collection Practices and Policies Domain: How is the Data Collected?**

The data collection practices and policies domain fosters data-collection environments free of stigma. This domain evaluates the policies and workflows, including scripts for data collection, which ensure the consistency of non-stigmatizing and motivational interviewing practices. It also assesses the policies and practices for sharing pronouns across the care team to promote inclusivity and respect.

**Language Services Policies and Practices Domain/ Screening for Language Needs/ Record Service Provision for Language Needs: How is Data Used to Provide Accommodations for Language Services?**

The language services policies and practices domain evaluate the following:

- *Screening for Limited English Proficiency (LEP):* How we screen Members for LEP and identifying Members whose preferred written and spoken language is not English.
- *Documentation of Interpretation Services:* Whether the need for interpretation services is documented in a specific field within the EHR.
- *Sharing Information Across the Care Team:* How we share information about the Member's need for interpretation services across the care team.
- *Resource Availability for Providers:* How the FQHC or Affiliated Participating Provider makes resources available to providers, including how to obtain interpretation services.
- *Provision of Interpretation Services:* Whether the FQHC or Affiliated Participating Provider documents interpretation service provision is in a specific field in the EHR.
- *Staff Language Proficiency Evaluation:* How the FQHC or Affiliated Participating Provider evaluates the language proficiency of staff who are not certified interpreters but provide interpretation services (if applicable).

- *Timeliness of Translated Information:* Whether the FQHC or Affiliated Participating Provider stipulates how long it may take for Members to receive translated written information from the date of the request.
- *Quality Evaluation of Translated Information:* How the FQHC or Affiliated Participating Provider periodically evaluates the quality of translations.

In 2024, Participating FQHCs and Affiliated Participating Providers will report on the percentage of Members who indicate needing interpretation services and received them. The pay-for-reporting threshold for 2025 is at least 50%, and it is likely to increase to pay-for-performance threshold of 75% in 2026 and to 85% in 2027.

**Screening for Disability Accommodations/ Record Service Provision for Disability Accommodations Needs: How is Data Used to Provide Accommodations for Disabilities?**

Like language services, this domain evaluates the extent to which FQHCs and Affiliated Participating Providers screen members for disability accommodation needs and records the screening results in a specific field in the EHR. They also assess the proportion of Members who receive accommodations they request out of all members who indicate the need for accommodations. The pay-for-performance thresholds are set to begin tentatively in 2026, requiring 50% of members to be screened, and increasing to 65% in 2027.

**Implementing Interventions to Address Healthcare Inequities Domain: How is Data Used to Reduce Disparities in Outcomes?**

This domain encourages the stratification of data to identify disparities in outcomes and the implementation of interventions to achieve health equity. The process of stratifying data and identifying Member segments experiencing disparities will be conducted by our Organization at the central level, with relevant FQHCs and Affiliated Participating Providers engaged in implementing the interventions.

This domain includes training the entire FQHCs' and Affiliated Participating Providers' workforce who interacts with MassHealth Members in racial equity. We will provide base trainings, which FQHCs and Affiliated Participating Providers can encourage their staff to complete.

Additionally, this domain requires us to train the FQHC and Affiliated Participating Providers workforce in disability-competent care, with pay-for-performance thresholds set at 5% in 2024, 20% in 2025, 35% in 2026, and 50% in 2027.

**Practitioner Race/Ethnicity and Language: What is the Demographic Profile of Our Providers?**

This domain addresses MassHealth's requirement to make information about our providers' linguistic proficiencies available in the provider directory on our website and their race/ethnicity information available upon request. Our Participating FQHCs and Affiliated Participating Providers are asked to collect this information and submit it to C3 via an existing process.

### Evaluation of the Delegation Agreements

At the end of each year, we send a questionnaire to the COO (or designated contact) of each FQHC and Affiliated Participating Providers. The questionnaire is completed and returned along with supporting documentation. Based on the responses, we update the Health Equity Score dashboard.

## 7.3 Other Contractual Requirements

### The Community and Population Needs Assessment (CPNA)

We conducted our initial CPNA in 2021 and anticipate refreshing the data in 2024 in collaboration with FQHC and Affiliated Participating Provider point persons where appropriate.

### The Health Equity Strategic Plan

We developed a Health Equity Strategic Plan that outlines our priorities for advancing health equity in 2022. An annual update of the strategic plan will begin at the end of 2024.

### The Health Equity Committee

The Health Equity Committee is an integral part of our governance structure, composed of FQHC providers, staff, and Members. Its mandate is to oversee the implementation of the Health Equity Strategic Plan and the activities of the Health Equity Incentive Program. Participation in the committee is voluntary. If your FQHC would like representation, please email the Director of Health Equity, or contact your Practice Transformation Manager.

### The Patient and Family Advisory Council (PFAC)

The PFAC convenes quarterly to provide input on our quality and health equity plans, bringing the Member voice to inform how we deliver care. Participation in the council is voluntary. If your FQHC or Affiliated Participating Provider would like representation, please email the Director of Health Equity, or contact your Practice Transformation Manager.

# Section 8. Risk Adjustment

## 8.1 Risk Score Overview

### MassHealth Risk Score

Risk adjustment is a method used by payers like MassHealth to determine predicted cost relative to Member complexity. MassHealth "risk adjusts" payment to ACOs for total population complexity. ACOs with more complex Members are eligible to be compensated *more than* ACOs with less complex Members because MassHealth expects care to cost more for complex Members and patients. MassHealth assigns each Member a risk score, which is a numeric indicator of Member complexity. The average MassHealth risk score is 1.0.

### MassHealth Risk Adjustment Model

MassHealth utilizes a version of the Diagnostic Cost Group (DxCG) and Prescription Drug Cost Group (RxCG) risk adjustment model to calculate risk scores. This model uses ICD-10 diagnoses, age, gender, prescriptions filled, and certain social and behavioral factors with a known impact on health. In order to be included in risk scores, ICD-10 diagnoses must be on a paid claim. MassHealth considers any billable provider claims in risk score calculation. Claims from certain non-diagnosing providers (like radiology) are weighted less in the risk score. Diagnoses must be documented at least once per calendar year to count in the risk score.

Unique to the MassHealth risk adjustment model is consideration of housing instability as a predictor of costs. MassHealth periodically evaluates the efficacy of the model to predict costs and revise the model. The current model is MassHealth SDH 4.0.

### C3 Risk Adjustment Program

Our Organization has a risk adjustment program that is responsible for partnering with providers to ensure that Participating Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers receive accurate risk adjustment for Member complexity. The risk adjustment program staff includes subject matter experts in risk adjustment, revenue cycle operations, provider education, and actuarial/risk analytics. It additionally includes certified coders available to our FQHCs and Affiliated Participating Providers on request. FQHCs and Affiliated Participating Providers in need of assistance in risk adjustment may

contact their designated Practice Transformation Manager for further information and support.

## 8.2 Risk Adjustment and Compliance

### Compliance with Regulatory Requirements

We encourage providers to follow ICD-10 CM guidelines for accurate coding. Clinical documentation should contain a SOAP (subjective, objective, assessment, and plan) or MEAT (Monitor, Evaluate, Assess, and Treat) note to support each ICD-10 billed. We encourage providers to adopt policies and procedures to ensure that ICD-10 diagnoses billed follow ICD-10 CM guidelines, and that ICD-10 diagnoses billed on a claim are supported by adequate clinical documentation.

## 8.3 Risk Adjustment and Impact on Finances

Each year, MassHealth sets a global budget for ACOs and adjusts that budget for Member (patient) complexity. The risk score is the numeric indicator of patient complexity. For example, an ACO with an average risk score of 1.1 receives a greater budget per Member per month than an ACO with an average risk score of 0.9.

Because the risk score is impacted by ICD-10 diagnoses, providers that do the following are best positioned to receive accurate risk adjusted payment:

1. Document chronic conditions routinely each year during a patient visit.
2. Follow ICD-10 CM guidelines for coding specificity and use the most specific iteration of the condition rather than an unspecified diagnosis or symptom.

Financial reconciliation between C3 and providers is done according to the terms in the Participation Agreement.

## 8.4 Reporting

Risk score reports are available at the practice, provider, and patient level. Practice and provider-level reports include, but are not limited to, risk score trend and chronic condition documentation trends over time. Patient-level reports include, but are not limited to, notation of previous and current risk-adjusted conditions. Our Organization has a desktop population health software that contains these elements. For additional reporting needs, and/or access to the population health platform, please contact us at c3support@c3aco.org.

# Section 9. Population Health Support and Performance Management

## 9.1 Practice Transformation Team

The Practice Transformation Team (PTX) is a cross-functional team that works hand-in-hand with our Participating Federally Qualified Health Centers (FQHCs) and Affiliated Participating Providers. Each Participating FQHC or Affiliated Participating Provider is assigned a PTX Manager who partners with each leadership team to support, monitor, and promote performance across our various programs and MassHealth deliverables. PTX Managers are true generalists with subject matter expertise in the full scope of our Organization's business operations. These include, but are not limited to, Care Management, Risk Adjustment, Quality, Practice Transformation, EHR optimization, and population health platform technology optimization.

## 9.2 Structure of Support

The role of the PTX Manager is to provide high-touch support to each Participating FQHC and Affiliated Participating Provider. Monthly meetings (either in-person or virtual) with our FQHC or APP leadership teams are required to review performance metrics and progress throughout the year. Additionally, PTX Managers meet with Quality, Risk Adjustment, Health Equity, and Clinical Operations leads frequently to assist, provide guidance, and receive updates on targeted initiatives. PTX Managers work collaboratively with all Participating FQHCs or Affiliated Participating Providers and are a great resource for best practice sharing and connecting staff across our network.

# Section 10. Compliance, FWA, and HIPAA Regulations

## 10.1 General Compliance

Our Organization is fully committed to conducting its activities in compliance with all Federal, State, and local laws and regulations and in conformance with the highest standards of business integrity. All policies, standards and procedures reflect the dedicated commitment of our Organization's Board of Directors to remain fully compliant with legal, regulatory, and ethical standards.

Our Compliance Department is designed to assist stakeholders inclusive of employees, Participating Federally Qualified Health Centers (FQHCs), Affiliated Participating Providers, vendors, contractors, and board members by establishing a general overall framework for conducting our activities with integrity and accountability for a shared set of ethical and legal principles, as well as to prevent, detect and correct noncompliance with all contractual requirements.

### Designated Compliance Officer

While ultimate responsibility and oversight of our compliance activities rest with the Board of Directors, the Compliance Officer is the focal point of all compliance activities and should be viewed by all employees, Participating FQHCs, Affiliated Participating Providers, vendors, and contractors as a valuable and confidential resource for questions related to compliance.

The Compliance Officer is responsible for:

1. Overseeing all day-to-day aspects of the compliance program
2. Ensuring the effectiveness of the compliance program through auditing and monitoring
3. Ensuring alignment of the compliance program with applicable Federal and State laws and regulations and organizational policies and procedures
4. Ensuring that adequate education and training is provided to all employees, Participating FQHCs, Affiliated Participating Providers, vendors, contractors, and board members managers on various aspects of our compliance activities

5. Developing policies and procedures designed to ensure compliance and to assess whether our Organization is, in fact, meeting its obligations
6. Reporting regularly to the Board of Directors on the progress regarding ongoing compliance with applicable laws
7. Receiving and investigating reports of potential non-compliance or other conduct that may violate applicable laws, regulations, and policies
8. Developing policies that encourage reporting of non-compliance or suspected fraud, waste, and abuse without the fear of retaliation

## Written Policies, Procedures, and Standards

Our Organization has established policies, procedures, and standards to ensure its business and operations are conducted in accordance with ethical obligations, and legal and regulatory requirements.

We review and update policies on an annual basis or as required by regulatory changes. On a yearly basis, the Compliance Department shares the Compliance Manual with FQHCs and Affiliated Participating Providers so that they can attest to their own internal policies aligning with our Organization's Compliance policies.

Adherence with contractual and regulatory requirements is the best way to ensure our Organization meets its obligations under the law and therefore such adherence is a job requirement of all.

## Education and Training

Our Compliance Department conducts training on all applicable compliance requirements as appropriate. Contractors, such as those providers/suppliers who have entered into a participation agreement are provided with a copy of the Compliance Manual and are contractually committed to adhering to all applicable laws and regulations. The Compliance Officer offers training to Participating FQHCs and Affiliated Participating Provider compliance leads during onboarding of new providers and more frequently as deemed appropriate. Participating Health Centers and Affiliated Participating Providers must ensure that their staff complete required compliance education. Completion of compliance education needs to be documented in accordance with existing systems used by Participating FQHCs and Affiliated Participating Providers. At a minimum, such documentation must include a) the name, organization and department of the workforce member participating in the

education, b) the completion date, and c) a summary of the education materials used in the training.

At a minimum compliance education training must cover:

a. Grievances
b. HIPAA, Confidentiality, and Privacy
c. Minimum Necessary Disclosure of Protected Health Information (PHI)
d. Regulatory Requirements
e. Marketing Materials
f. Fraud, Waste, and Abuse
g. Whistle-Blower Protections; and,
h. Record Retention

## Communication Processes Including Hotline

Our Organization is subject to numerous Federal and State laws and regulations. Therefore, it is vitally important for all employees, Participating FQHCs, Affiliated Participating Providers, vendors, contractors, and board members (C3's Stakeholders) to be vigilant regarding compliance within this complex legal and financial system. Accordingly, it is the responsibility and expectation of all to report concerns regarding suspected noncompliance. To assist and facilitate in the confidential identification of potential compliance issues, we have established mechanisms for private communication of potential compliance issues. These mechanisms include:

1. A hotline 1-844-560-0077 (English) or 1-800-216-1288 (Spanish) by which any person (including any Members, employees, Participating FQHCs, Affiliated Participating Providers, vendors, contractors, and board members) may report any issue on an anonymous basis. Callers may also feel free to identify themselves so that additional questions can be asked to aid in our resolving the issue.
2. Open communication with the Compliance Officer, whose duty is to ensure total compliance by our Organization. Please feel free to contact the Compliance Officer directly with questions or concerns. It is the policy of our Organization that sincere participation in the compliance program including the reporting of any suspected noncompliance or other issue will not result in retaliation against the participant. Individuals shall not be intimidated or retaliated against in response to their sincere adherence to this compliance program.

3. Any potential instances of non-compliance should be reported to the Compliance Officer within three (3) business days by emailing compliance@c3aco.org.

## Compliance with Contractual Requirements

Member-facing staff needs to be familiar with Member Rights. There are clearly defined rights granted to all Members. The full list can be found in Section 2.3 of this manual or the Member Handbook.

Members need to be notified in writing at least 30 days in advance of a provider leaving an FQHC or Affiliated Participating Provider and given information on how services will continue. The Organization delegates this contractual responsibility to all Participating FQHCs and Affiliated Participating Providers.

## Well-Publicized Disciplinary Measures

Compliance with all applicable laws and regulations is a requirement for our Stakeholders. It is also, as noted above, an expectation of all that compliance issues such as noncompliance or unethical behavior are identified and reported. Failure to comply with this requirement may result in disciplinary action.

The type and severity of the action will depend on the particular facts and circumstances but serious deviations from these requirements may result in termination of a participant from the Organization, or termination of employment of an employee or contractor. It is the policy of the Organization that it will institute timely, consistent, and effective enforcement of the disciplinary standards.

## Routine Monitoring, Auditing, Record Retention, and Identification of Compliance Risks

Ongoing monitoring and auditing are critical to a successful compliance program. The Compliance Officer periodically reviews aspects of our operations, especially in areas that have been identified by government enforcement agencies as potentially problematic. A particular area of focus is the Organization's compliance with its regulatory and contractual commitments. All our Stakeholders and other individuals or entities performing functions or services on behalf of C3 are required to:

1. Maintain and provide EOHHS, CMS, DHHS, or their designees access to all books, contracts, records, documents, and other evidence (including data relating to utilization and costs, quality performance measures, shared

savings distributions, and other financial arrangements relating to the Organization's activities) sufficient to enable the audit, evaluation, investigation, and inspection of compliance with program requirements, quality of services performed, right to any shared savings payment or obligation to repay losses, ability to bear risk of potential losses, and ability to repay losses.

2. Maintain such books, contracts, records, documents, and other evidence for a period of ten (10) years from the final date of the agreement period or from the date of completion of any audit, evaluation, or inspection, whichever is later.

## Responding to Detected Non-compliance and Non-retaliation

Any report received is thoroughly investigated. If upon review it is determined that our Organization has been noncompliant in some regard, the Compliance Officer will promptly take all appropriate actions required under the circumstances. The actual response will vary depending on the unique circumstances, but in all cases there will be steps taken to ensure future compliance. In some cases, we may be required to voluntarily self-report the matter to an appropriate authority.

Anyone who reports a concern, regardless of the method chosen, is protected from retaliation.

## A Shared Commitment by All

Our Organization's compliance with its legal duties depends on the actions of each and every one of its Stakeholders. The consequences of noncompliance can be extremely serious; therefore, we expect that all participants undertake their responsibility to remain compliant with respect and earnest intent. Those in a managerial or supervisory role have a special responsibility to ensure that those whom they are responsible for fully understand and completely adhere to all policies, standards, and procedures. All our Stakeholders are responsible for compliance with the law and together we can ensure that our mission will continue into the future with the highest of standards.

## Code of Conduct

At C3 all full-time employees, contractors, as well as committee and board members are expected to adhere to our Code of Conduct. The Code of Conduct ensures that all daily activities are conducted with appropriate ethical and legal standards. Each of the Organization's affiliated providers have their own Code of Conduct which serves the purpose of setting ethical and compliance expectations of

employees, vendors, and contractors. For more information, please see our Code of Conduct listed in Appendix A of this manual.

## Conflicts of Interest

All Conflict of Interest documentation (i.e., policy, Acknowledgment Form, and Disclosure Statement) is to protect the interests of our Organization when it contemplates entering into a transaction or arrangement with a Covered Person (i.e., any director, member of a committee with powers delegated by the Board of Directors, principal officer, Member, employee having responsibilities similar to a director or principal officer, substantial donor to the Organization, or any person in a position to exercise substantial influence over the affairs of the Organization, regardless of whether such person is compensated by the Organization, and any Family Member of such person).

Conflicts may arise when a Covered Person's interests are, or appear to be, averse to the interests of the Organization and if the Covered Person is in a position to influence a decision of the Organization in such a way that it will or might appear to benefit the Covered Person. The conflict of interest policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit organizations.

Each Covered Person shall, upon first acceding to such office or position, and then annually thereafter, sign an Acknowledgement Form, which affirms that such person:

a) has received a copy of the conflict of interest policy;
b) has read and understands the conflict of interest policy;
c) has agreed to comply with the conflict of interest policy;
d) understands that C3 is a social welfare organization and in order to maintain its federal tax exemption the Organization must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

Persons subject to the Conflict of Interest policy are also required to complete a Conflict of Interest Disclosure Statement, and to update the Disclosure Statement immediately following any change in the information requested on the Disclosure Statement.

## 10.2 Non-Discrimination Statement

We comply with applicable Federal civil rights laws and does not discriminate on the basis of health status or need for health care services, race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Our Organization does not exclude people or treat them differently because of their health status or need for health care services, race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information printed in other languages

We make the Notice of Discrimination available to all Members. If a Member feels as if they have not been treated fairly for any of the reasons outlined in the Notice of Nondiscrimination statement, they may call the Department of Health and Human Service's Office for Civil Rights at 800-368-1019 (or TTY: 800-537-7697 for people who are deaf, hard of hearing, or speech disabled), or visit hhs.gov/ocr/office/index.html for more information. Members may also file a grievance. For more information on the grievance process, please see COMP-011: *Member Protections – Grievances* policy in Appendix A.

# Section 11. Technology and Systems

## 11.1 Access Control

All computer systems within our Organization, our Participating Federally Qualified Health Centers (FQHCs), and Affiliated Participating Providers must require user identification and passwords for gaining access to systems and data. This policy applies to all users: company staff, students, temporary staff, and contractors. The security of these passwords determines the security of the data itself. All workstations are configured such that a password is needed to "power up" the system. Even locally-stored applications cannot be accessed without a valid network password.

All passwords that provide access to computer applications are employee-specific and are not to be shared with others for any reason. Passwords must never be written down where others could find them. If a user feels that another person may have learned their password, it is their responsibility to change their password immediately.

Password length and complexity defend the account from automated processes that attempt to gain access by "guessing" the password. Network passwords must be a minimum of 8 characters in length and contain at least one alpha, one numeric, and one distinctive character. Users are required to change their passwords every three months, to further ensure that passwords are secure and will receive a system generated prompt. The system should track if the user has previously used a password, and not allow the reuse of that password by that person in the prior 3 years. Application password policies are consistent with network password policies whenever possible.

Adherence to the access and security policies should be automated whenever possible, for example, by implementing an identity management system that provides Single Sign On (SSO) capabilities.

It is required that IT reassigns passwords that are forgotten by the user. However, IT does not reassign the password over the phone without appropriate confirmation of the person's identity.

The use of "general access" passwords must be limited to workstation access only. For example, there may be a general password assigned that allows a user to power up a workstation that is located in a public area. However, the use of applications is limited, and the application security is in effect.

Application access must be granted in a manner that is appropriate to the employee's role and job responsibilities and must not be provided until the employee has completed required training for that application.

Any attempt to gain access to systems for which the employee is not authorized should be considered a security breach.

Periodic review of user lists and the levels of those users' access closes gaps that may arise when employees' responsibilities change. Application and network administrators may provide supervisors with this information to review and confirm that their employees' current access is still appropriate.

The removal of access to our Organization's network and application resources when an employee leaves by resignation or termination, either urgently or with notice, must be a component of the Organization's standard separation from services procedures.

## 11.2 Auditability of User Activity

To address standards set forth by the HIPAA Security Rule and to ensure that C3, Participating FQHCs and Affiliated Participating Providers can protect Member privacy and business confidentiality within the electronic systems to manage total cost of care, quality management and reporting, and population health, all user activity within those systems and tools is subject to being audited on a planned and unplanned basis. Audits may also be performed for a specific cause including patient complaints, employee/participating provider complaint, suspected breach of patient confidentiality, or an elevated risk event. Any findings related to an unauthorized breach are reported to the Organization's Compliance Officer.

## 11.3 Device Management

The purpose of strong device management is to ensure that only authorized users may operate a certain device and access data stored there, and that those users are provided with the appropriate software tools to perform their duties with that device, and that only authorized programs and instructions (i.e., not computer viruses) can be executed on the device. Thoughtful initial configuration of devices and attentive management thereafter is required to ensure that these tools and protections remain effective and up to date. Automating these processes to the greatest extent possible will increase their timeliness and reliability.

Access controls as described in Section 11.1 and Antivirus and Protections Against Malicious Code in Section 11.5 of this manual, address a subset of these requirements.

Devices must also be configured to "lock" and require re-entry of the user's password after a period of inactivity. The locking threshold must be three minutes or less.

Additional protections should be applied to the physical device. Importantly, only devices with encrypted local storage may hold Protected Health Information (PHI) or Personal Information (PI), or other confidential business information. Paper printers commonly include local storage and must meet encryption requirements.

Even greater attention must be paid to devices that are fundamentally mobile, including laptop computers, tablets, and smartphones. Best practices for managing these devices include:

- minimizing the use of local data storage (i.e., maintaining data in the cloud);
- requiring multi-factor authentication for device and application access;
- providing remote "wiping" capabilities that would allow the deletion of data if the device were lost or stolen.

## 11.4 Protected Health Information (PHI) and Personal Information

All of our employees, Participating FQHCs, and Affiliated Participating Providers are responsible for maintaining the privacy and integrity of Protected Health Information (PHI) and Personal Information (PI). An employee who discloses PHI or PI or fails to comply with these policies protecting PHI or PI may face immediate disciplinary action.

Our Organization, Participating FQHCs, and Affiliated Participating Providers recognize the importance of maintaining the security of PHI and PI and, therefore, comply with all laws regulating the retention of such information. For purposes of this policy, "personal information" is defined as a person's name (either the person's first and last names, or the person's first initial and last name) in combination with the person's Social Security number, driver's license or state-issued identification number, financial account number, or credit or debit card number. PHI and PI may be found in printed documents and hard files, and may also be collected, accessed, and stored electronically. The requirements to protect PHI and PI apply whether it is printed or electronically stored.

Our Organization and Participating FQHCs commonly exchange PHI in support of treatment, payment, or operational processes—all HIPAA-compliant scenarios. Participating FQHCs and our Organization each configure their respective email servers to enforce Transport Layer Security (TLS) encryption when connecting with others' email servers.

The Organization's Compliance Officer is responsible for ensuring that Business Associate Agreements with FQHCs, Affiliated Participating Providers, and/or Payors and Business Associate Subcontractor Agreements with vendors are in place when needed. All Employees are responsible for ensuring that the Organization's handling of PHI is consistent with the applicable Business Associate Agreement(s).

Employees are required to take all reasonable measures to limit access to PHI and PI, and to limit the collection or retention of such information to only what is necessary to accomplish the legitimate purpose for which the PHI and PI is collected, stored, or accessed. To meet our Organization's obligation to maintain security of personal information, employees are required to comply with all information security laws and regulations, and any other policies and programs adopted by us, Participating FQHCs, and Affiliated Participating Providers. This includes:

- keeping verbal conversations about PHI private;
- refraining from reading PHI unless required to fulfill job responsibilities;
- using care when faxing PHI to ensure that the PHI is sent to the correct recipient;
- securing PHI so that it is not left in plain sight;
- positioning files so they maintain confidentiality;
- reviewing, understanding, and complying with the breach notification policies & procedures and notifying the Organization's Compliance Officer if a suspected breach has occurred;
- training on privacy requirements, PHI, and security policies annually.

## 11.5 Antivirus and Protections Against Malicious Code

Protecting computers, computer systems and other digital devices from computer viruses and other malicious code prevents major damage to and loss of information from hardware, applications, and user data.

All computers and devices that store our Organization's information and that at any time connect to the Organization's network must have approved and supported anti-virus software correctly installed, configured, activated, and updated with the latest virus definitions. Mobile devices do not require anti-virus software but are required to be enrolled in the company portal using Microsoft Authenticator which ensures device compliance and mitigates risk from harmful applications while accessing the Organization's network. Any exceptions to this policy must be approved in advance by the Director of IT.

If a particular operating system or computing platform does not have anti-virus protection available, use of a device using such an operating system must be approved by our IT department, who shall determine the operating procedures necessary to minimize the possibility of malware infecting the corporate network. If anti-virus software becomes available for an operating system or computing platform previously lacking such software, it must be installed as soon as possible on all such devices.

When an enterprise-wide malware attack is in progress, our IT department must notify all users via the best available method. After such an attack has been identified, all local storage devices must be scanned using the latest virus detection available, and cloud-based storage scanned to the greatest extent allowed by service provider.

# Appendices

Appendices and documents listed in this Section are available to our Participating Federally Qualified Health Centers and Affiliated Participating Providers only. These documents are password protected and are posted separately on our website. To request a password, please contact c3support@c3aco.org.