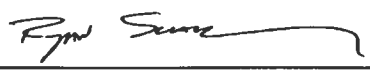
DISCLOSURE BY STATE EMPLOYEE OF FINANCIAL INTEREST IN A CONTRACT TO PROVIDE SOCIAL SERVICES PURSUANT TO 930 CMR 6.07

	STATE EMPLOYEE INFORMATION
Name of state employee:	Lee Robinson
Title/ Position:	Chief of Accountable Care and Behavioral Health
Agency/Department:	MassHealth
Agency Address:	One Ashburton Place, Boston, MA 02108
Office phone:	508-254-1987
Office e-mail	Lee.Robinson@mass.gov
	I am a state employee, and I seek to have a financial interest in a contract or agreement made by a state agency listed below, or by a provider or organization funded by a state agency listed below: A state agency within the following Executive Offices: Executive Office of Health and Human Services, including the Human Service Transportation Office; Executive Office of Public Safety and Security, Executive Office of Elder Affairs, Executive Office of Veteran's Services, or A sheriff's office. The purpose of the contract is: - To provide personal services to a person or persons who receive services from, or have services paid for by, these state agencies; or - To provide educational services to people who work for these state agencies or for providers or organizations funded by these state agencies. I seek approval of the arrangement from the agency for which I serve as a state employee and from the state agency above that made the contract.
	FINANCIAL INTEREST IN A CONTRACT WITH A STATE AGENCY
	PLEASE CHECK OFF ONE OF THE THREE STATEMENTS BELOW AND PROVIDE THE REQUESTED INFORMATION.
1) Service to a state agency	___ I will provide personal or educational services to a state agency listed above. Please identify the state agency and also the Executive Office it is in, if applicable.

2) Service to a provider or organization	_X_ I will provide personal or educational services to a provider or organization funded by a state agency listed above. Please provide the name and address of the provider or organization. **UMass Memorial Medical Group, Dept of Psychiatry (55 Lake Avenue North, Worcester, MA 01655)** **Massachusetts Child Psychiatry Access Program (MCPAP) for Autism Spectrum Disorders and Intellectual Disabilities (ASD-ID)** Please identify the state agency that funds the provider or organization, and also the Executive Office it is in, if applicable. **Executive Office of Health and Human Services (EOHHS) via the Massachusetts Behavioral Health Partnership (MBHP)**
3) Service to a person or persons	___ I will provide personal services directly to a person or persons who receive services from, or have services paid for by, a state agency listed above. Please identify the state agency that provides services to, or pays for services for, the person or persons, and also the Executive Office it is in, if applicable.
Please describe the services you will provide.	Please provide information about the type of personal or educational services you will provide. **Please do not include the name of any individual who receives services.** **I will work in a part-time clinical role for the UMass Memorial Medical Group's Department of Psychiatry, as a child/adult psychiatrist in the Massachusetts Child Psychiatry Access Program (MCPAP) for Autism Spectrum Disorders and Intellectual Disabilities (ASD-ID). In this role, I will evaluate youth and young adults with ASD or ID, and their families, to offer consultative recommendations to them and their treatment teams.** **UMass Memorial Medical Group receives funding to support their role in the MCPAP for ASD-ID program from the Massachusetts Behavioral Health Partnership (MBHP), which is funded for this program by the Executive Office of Health and Human Services (EOHHS).**
What will you be paid, or what other financial interest will you have?	Please include a dollar amount, if possible. **$150/hour before taxes, 4 hours per week**
Employee signature	
Date:	10/16/26
	APPROVAL BY AGENCY YOU SERVE AS A STATE EMPLOYEE
Name and title of appointing authority	Ryan Schwarz Medicaid Director & Assistant Secretary for MassHealth
Office phone	617.290.5726
Office e-mail	Ryan.Schwarz@mass.gov
Signature by appointing authority	By signing here, I indicate that I have reviewed the facts that the state employee has disclosed above and approve the arrangement proposed by the state employee. 

Date:	10/20/2026
	APPROVAL BY AGENCY THAT MADE THE CONTRACT (IF DIFFERENT)
Name and title of person giving approval at the state agency that made the contract	
Office phone	
Office e-mail	
Signature by person giving approval	By signing here, I indicate that I have reviewed the facts that the state employee has disclosed above and approve the arrangement proposed by the state employee.
Date:	

Attach additional pages if necessary.

File with:

State Ethics Commission
One Ashburton Place, Room 619
Boston, MA 02108

Form revised February, 2012