Appendix A: Exhibit 1

RI Medicaid - State MCO Standards

MCO Contract Language

Section 2.09 – Service Accessibility Standards
The Contractor will establish and implement mechanisms to ensure that network providers comply with the access and timely appointment availability requirements set forth herein. The Contractor will monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply.

The Contractor agrees to comply with any requests for data from the EOHHS' External Quality Review Organization (EQRO) in the conduct of any access-related focused studies.

2.09.01 Twenty-Four Hour Coverage
The Contractor must provide access to medical and behavioral health services and coverage to members either directly or through their PCP on a twenty-four (24) hours a day, seven (7) days a week basis. The Contractor must educate members on how to access services after regular business hours and on weekends. The Contractor may satisfy this requirement by requiring all PCPs to assume the primary responsibility for 24/7 after hours on call telephone services.

2.09.02 Travel Time
The Contractor will develop, maintain and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State established provider-specific network adequacy standards. The contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided in the table below. Members may, at their discretion, select a participating PCP located farther from their home.

Provider Type	**Time and Distance Standard** *Provider office is located within the lesser of*
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.

Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

These network standards will include all geographic areas covered by the Contractor, EOHHS may, at its sole discretion, grant the Contractor exceptions to the time and distance standards. The Contractor will request an exception in writing and will provide evidence supporting the request to EOHHS. EOHHS's approval of an exception will be in writing. Should EOHHS permit an exception to these time and distance standards, access to that provider type will be monitored by EOHHS on an ongoing basis and may result in additional reporting requirements for the Contractor. These standards will be published on the EOHHS web site and will be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

2.09.03 Emergency Medical Services

Pursuant to 42 CFR 438.114, Contractor agrees to provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in Contractor's own facilities or through arrangement, with other providers. The Contractor agrees that services shall be made available immediately for an emergent medical condition including a mental health or substance use disorder condition. In accordance with 42 CFR 438.114(d)(1)(I), the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, as specified in 42 CFR 438.114(b) as responsible for coverage and payment.

The Contractor must cover and pay for Emergency Services, as defined herein, regardless of whether the provider that furnishes the services has a contract with the Health Plan. The Contractor will reimburse non-contracted providers for emergency services in an amount that is no greater than what would have been paid had the service been paid under FFS. In accordance with 42 CFR 438.114 (d)(1)(ii), the Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or Health Plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. A member who has an emergency medical condition, behavioral health or substance use disorder condition as defined herein, may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Contractor may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. The Contractor may not deny payment for treatment, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The Federal and State requirements governing emergency services will be provided to members in a clear, accurate and standardized form at the time of enrollment and annually thereafter.

2.09.04 Appointment Availability

The Contractor agrees to make services available to members as set forth in the requirements below:

Appointment	Access Standard
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	30 calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 10 calendar days

2.09.05 Post-Stabilization Care Services

Post-Stabilization Care Services will be provided to members in accordance with the definition set forth in Section 1.87 members have the right to receive Post-Stabilization Care Services after they have been stabilized following an admission for an emergency medical condition; provided, however, that the provider of Post-Stabilization Care Services must request prior authorization for those services in accordance with the provisions of this Agreement and the Contractor. The Contractor must pay for Post-Stabilization Care Services if: (1) the Contractor pre-approved such services; (2) the Contractor authorizes those services in accordance with the provisions of the Health Plan; (3) the Contractor did not respond to the request for prior authorization within one hour of the request; (4) the Contractor cannot be contacted; or (5) the

Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Contractor's physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Plan physician and the treating physician may continue with the care of the patient until a Plan physician is reached or one of the criteria of 42 CFR 422.133(c) is met. The requirements of Federal and State law governing Post-Stabilization Care Services will be provided to members in clear, accurate, and standardized form at the time of enrollment and annually thereafter.

The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: (1) a Health Plan physician with privileges at the treating hospital assumes responsibility for the member's care; (2) a Health Plan physician assumes responsibility for the member's care through transfer; (3) the Contractor's representative and the treating physician reach an agreement concerning the member's care; or (4) the member is discharged as specified in 42 CFR 438.114 (e).

The Contractor must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the Health Plan as indicated in 42 CFR 422.113.

2.09.06 Access for Women

The Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services and supplies.

2.09.07 Assessment Standards

The Contractor shall have assessment standards that comply with the Care Management Protocols in ATTACHMENT Q of this Agreement and are approved by EOHHS.

2.09.08 Health Risk Assessments

For all members, Contractor shall conduct a Health Risk Assessment with the member, caregiver or guardian. The Health Risk Assessment will be used to identify members who require short term care coordination or intensive care management for medical, behavioral or social needs.

The Contractor will: (1) provide the Health Risk Assessment to all members within ninety (90) days of enrollment; and (2) ensure the administration of the Health Risk Assessment to pregnant women and members with complex and serious medical or behavioral conditions within thirty (30) days of the date of identification.

2.09.09 Access for Members with Special Needs

In certain cases, members may have an ongoing clinical relationship with a particular specialist who serves as a principal coordinating physician for a member's special health care needs and who plays a critical role in managing that member's care on a regular basis throughout the year. The Contractor shall have policies and procedures whereby the member is ensured facilitated and timely access to such principal coordinating physician. Where this is the case, Contractor shall require communication and collaboration between the PCP and the specialist serving as the principal coordinating physician.

For members with special health care needs determined through an assessment by appropriate health care professionals, consistent with 42 CFR 438.208(c) (2)-(3) , who need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

2.12.03.06 Practice Guidelines

Contractor will develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236[i] and are based on valid and reliable medical evidence or a consensus of health professionals in the particular field, consider the needs of members, developed in consultation with contracting providers, reviewed and updated periodically as appropriate. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

[i] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.4 Practice Guidelines D.4.1 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. [42 CFR 438.236(b)(1)] D.4.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to adopt practice guidelines that consider the needs of the enrollees. [42 CFR 438.236(b)(2)] D.4.3 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to adopt practice guidelines in consultation with contracting health care professionals. [42 CFR 438.236(b)(3)] D.4.4 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to review and update practice guidelines periodically as appropriate. [42 CFR 438.236(b)(4)] D.4.5 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE disseminate the practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. [42 CFR 438.236(c)] G. Quality and Utilization Management

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. G. Quality and Utilization Management G.4 Staffing Training G.4.1 [Applies to MCO, PIHP, PAHP] The contract requires that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. [42 CFR 438.236(d)]