Attachment B:

AE Attestations and Assurances

Organization Name: _____

Commitment to AE Program Requirements

This assures that *(*) is a Rhode Island corporation or other legal entity able to accept certification with thestate and able to enter contractual relationships with MCOs to perform as a contracted Accountable Entity if certified:

- does not discriminate in its employment practices regarding race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicapand complies with the Americans with Disabilities Act.
- commits to participating in the AE program in partnership with participating MCOs in accordance withthe established AE program requirements**,** of the application document.

As an executive with the authority to make decisions about this proposed application, I assure that I have read, understand, and commit, on behalf of ( ), to the following the guidance issued by EOHHS related to the AE Program:

- This program will be implemented through a Contractual Partnership(s) between ( ) and (one or more) Medicaid Managed Care Organizations. The full opportunity for incentive funds may be reduced if the Certified AE does not contract with one or more MCO's within 120 days of certification.
- Shares EOHHS's commitment to member choice and access, as described in the EOHHS's AE certification standards.
- Hereby affirms and acknowledges members' right to choose of provider. ( ) will not seek to limit or restrict attributed members to providers within the AE network. Furthermore, ( ) will not limit Medicaid beneficiaries' access toproviders based on their AE attribution.
- Agrees to progressive implementation of an Alternative Payment/Total cost of Care Methodology, as described in EOHHS's Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

I attest that I am an executive of ( ), with the authority to make decisions about this proposed application. I attest to all the statements above on behalf of ( ).

Sign here _____

(Insert name and title of authorized Executive)

Declaration of
Health Care-related Convictions, Offenses, Disbarments or Suspensions

Has ( ) or any of the Applicant's employees, agents, independent contractors, orsubcontractors have been convicted of, pled guilty to or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have been debarred or suspended by any Federal or State governmental body? (Applicant shall also include the Applicant's parent organization, affiliates, and subsidiaries.)

Yes ☐ No ☐

If “Yes”, provide an explanation with relevant details below.