2017-06

CONTRACT BETWEEN

STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

TUFTS HEALTH PUBLIC PLANS

FOR MEDICAID MANAGED CARE SERVICES

AMENDED JANUARY 10, 2022

TABLE OF CONTENTS

GENERAL PROVISIONS

This Agreement, including the attachments, hereto, is made and entered into effective July 1, 2021, between the Rhode Island Executive Office of Health and Human Services (referred to as "EOHHS", or "Executive Office", or the "State" in this Agreement) and Tufts Health Public Plans (the "Contractor"). This Agreement ("Agreement") is entered into in conformity with EOHHS procedures.

ARTICLE I: DEFINITIONS

As used in this Agreement each of the following terms will have the indicated meaning unless the context clearly requires otherwise:

1.01 ABUSE

In accordance with 42 C.F.R. §438.2 (citing 42 C.F.R. §455.2), abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

1.02 ACCOUNTABLE ENTITY

An accountable entity is an integrated network consisting of an inter-disciplinary provider organization that is financially accountable for member cost, quality and health outcomes for Medicaid populations within value-based payment arrangements.

1.03 ACTIVE CONTRACT MANAGEMENT (ACM)

Active Contract Management (ACM) is a set of strategies that applies high-frequency use of data and purposeful management of agency-service provider interactions to improve services of contract. ACM consists of the following elements: (1) Contractor to detect and rapidly respond to problems; (2) Make consistent improvements to performance; and (3) Identify opportunities for reengineering service delivery systems.

1.04 ACTUARY

In accordance with 42 C.F.R §438.2, an actuary is an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

1.05 ADVANCED DIRECTIVE

An advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

1.06 ADVANCED PRACTICE PRACTITIONERS

Advanced Practice Practitioners include physician assistants, certified nurse practitioners, and certified nurse midwives. These individuals are subject to the laws and regulations of Rhode Island and may not exceed the authority of these regulations.

1.07 ADVERSE BENEFIT DETERMINATION

In accordance with 42 C.F.R. §438.400, an adverse benefit determination means any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of the Contractor to act within the timeframes provided in 42 C.F.R §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals

(6) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii), to obtain services outside the network; and,

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

1.08 AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act and the Health Care and Reconciliation Act of 2010 are commonly referred to as the Affordable Care Act (ACA). ACA is intended to improve the healthcare system and provide affordable quality of care to all Americans, lowering the

uninsured rate by expanding public and private insurance coverage, and reduce the cost of care for individuals and government through a variety of measures. ACA requires businesses with more than fifty employees to provide health insurance to full-time employees and requires individuals to purchase health insurance. Subsidies are available to those who cannot afford health insurance. ACA establishes Affordable Insurance Exchanges to enable employers and individuals to purchase health insurance through a competitive marketplace. ACA prevents insurance companies from denying coverage to those with pre-existing conditions, eliminating life-time limits on benefits, and allow young adults up to twenty-six (26) years old to remain on their parent's insurance policy.

1.09 AFFORDABLE CARE ACT ELIGIBLES

ACA extends and simplifies Medicaid eligibility for adults and enables States to expand Medicaid eligibility to certain adults age 19 or older and under 65, referred to as the Expansion population.

1.10 AGREEMENT OR CONTRACT

This document is referred to as an Agreement or Contract between EOHHS and the Contractor.

1.11 APPEAL

A review by an MCO, PIHP, or PAHP of an adverse benefit determination, that is in accordance with 42 C.F.R. §438.400.

1.12 CAPITATION PAYMENT

In accordance with 42 C.F.R. §438.2, capitation payment is a periodic payment made by the State to a contractor on behalf of each beneficiary enrolled under a contract based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

1.13 CARE COORDINATION

Care coordination is defined as the organized delivery of member care activities between two (2) or more participants (including the member) involved in a member's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all medically necessary member care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

1.14 CARE MANAGEMENT

Care management means a set of person-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links members to services as necessary across providers and settings. Care Management is provided to high risk populations such as but not limited to, individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional institutions. At a minimum, care management functions must include, but are not limited to: (1) Health Risk Assessment for all members; (2) Short term care coordination, where appropriate; and, (3) Intensive Care Management, when appropriate. Care Management is provided by a Program Coordinator or Care Manager who is properly licensed by the State.

1.15 CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND (CTC-RI)

The Care Transformation Collaborative of Rhode Island (CTC-RI) promotes the patient-centered medical home model of care throughout the State of Rhode Island. CTC-RI coordinates this work with all major health care stakeholders through the Patient-Centered Medical Home (PCMH) model to improve care, lower costs and promote better health outcomes for Rhode Islanders.

1.16 CASE MANAGEMENT

In accordance with 42 C.F.R §440.169, case management services means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with §441.18 of this chapter.

As with care management, case management activities also emphasize prevention, continuity of care, and coordination of care. Case management activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased member satisfaction; adherence to the care plan; improved member safety; and to the extent possible, increased member self-direction.

1.17 CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with special health care needs means those children with complex health conditions who are enrolled in managed care.

1.18 CHOICE COUNSELING

In accordance with 42 C.F.R. §438.2, choice counseling is the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.

1.19 CMS

CMS means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

1.20 COLD CALL MARKETING

Cold call marketing means any unsolicited personal contact by the Contractor with a potential enrollee for the purpose of marketing as defined in 42 C.F.R. §438.104.

1.21 COMMUNITY HEALTH TEAM

A health care program to assist members in obtaining care and services needed. Services include but are not limited to: primary care, member advocacy, health education and peer navigation.

1.22 COMPREHENSIVE RISK CONTRACT

In accordance with 42 C.F.R. §438.2, a comprehensive risk contract is a contract between the State and an MCO that covers comprehensive services, including inpatient hospital services and any of the following services, or any three (3) or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) Federally Qualified Health Center (FQHC) services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

1.23 CONTRACT SERVICES

Contract Services mean the services to be delivered by the Contractor, which are so designated in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement.

1.24 CONTRACTOR

The Contractor means the Health Plan (i.e. Tufts Health Public Plans) that has executed this Agreement with EOHHS to enroll and serve members under the conditions specified in this Agreement

1.25 CO-PAYMENT

A cost-sharing arrangement in which a covered person pays a specific charge for a specified service. This amount is paid at the time services are rendered.

1.26 COVERED SERVICES

Covered Services mean the medical (primary and acute), behavioral healthcare service; long-term care services and supports and benefits packages described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement.

1.27 DAYS

Days mean calendar days, which includes weekends and holidays, unless otherwise specified.

1.28 DOULA

As defined by the American College of Midwives, a doula is a person who has been specifically trained to provide nonmedical support to women during pregnancy, childbirth, and the postpartum period.

1.29 DEEMED NEWBORN ELIGIBILITY

Babies born to Medicaid-eligible pregnant women who are residents of Rhode Island are deemed eligible from the date of their birth. Once deemed eligible as a newborn, the infant remains eligible for one (1) year and, as such, this is a non-MAGI eligibility pathway. Accordingly, retroactive coverage is available for periods prior to the application date, if the newborn was otherwise deemed eligible.

1.30 DURABLE MEDICAL EQUIPMENT

Medical equipment and appliances are items that are primarily and customarily used to serve medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. Items that had previously only been offered under sections HCBS 1915 (c) and HCBS 1915 (i) that will now be covered under the home health benefit (e.g. grab bars). https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html.

1.31 EMERGENCY DENTAL CONDITION

Emergency Dental Condition means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, and eliminate acute infection, pulpal death, or loss of teeth.

1.32 EMERGENCY MEDICAL CONDITION

In accordance with 42 C.F.R. §438.114, an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

1.33 EMERGENCY MEDICAL SERVICES

Emergency medical services, also known as ambulance services or paramedic services (abbreviated to the initialism EMS, EMAS, EMARS or SAMU in some countries), are a type of emergency service dedicated to providing out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients.

1.34 EMERGENCY MEDICAL TRANSPORTATION

Ambulance services for an emergency medical condition.

1.35 EMERGENCY ROOM CARE

Refers to intensive services given in an emergency room or emergency care center. Care is administered to stabilize a patient's medical condition and/or prevent loss of life or worsening the condition.

1.36 EMERGENCY SERVICES

In accordance with 42 C.F.R. §438.114, emergency services means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title and (2) needed to evaluate or stabilize an emergency medical condition.

1.37 ENROLLEE

In accordance with 42 C.F.R. §438.2, an enrollee is a Medicaid beneficiary/recipient currently enrolled in a Medicaid Managed Care plan. For purposes of this Agreement, see definition in Section 1.77 'MEMBER OR MEDICAID MANAGED CARE MEMBER.'

1.38 ENROLLEE ENCOUNTER DATA

In accordance with 42 C.F.R. §438.2, enrollee encounter data is information relating to the receipt of any item or services by the enrollee under this contract.

1.39 EPSDT

In accordance with 42 U.S.C. §1396d(r), EPSDT means Early and Periodic Screening, Diagnosis and Treatment, a comprehensive set of services provided to all Medicaid-eligible children under age 21.

1.40 ESSENTIAL COMMUNITY PROVIDER

Providers that serve predominantly low-income, medically underserved individuals. CMS has identified six ECP categories: (1) Federally Qualified Health Centers (FQHCs) and FQHC "Look-Alike" clinics; (2) Ryan White HIV/AIDS Program Providers; (3) Family Planning Providers; (4) Indian Health Providers; (5) Hospitals; and (6) Other ECP Providers including STD clinics, TB clinics, Hemophilia treatment centers, Black Lung clinics and other entities that serve predominately low-income, medically underserved individuals.

1.41 EXCLUDED SERVICES

Refer to services not covered by the Medicaid State Plan – see Attachment C, NON-COVERED SERVICES.

1.42 EXECUTIVE OFFICE

Executive Office will mean the Rhode Island Executive Office of Health and Human Services (EOHHS).

1.43 FAMILY

Family means the adult head of household, his or her spouse and all minors in the household for whom the adult has parent or guardian status.

1.44 FRAUD

In accordance with 42 C.F.R. §438.2 (citing 42 C.F.R. §455.2), fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. Includes any act that constitutes fraud under State or Federal Law.

1.45 GRIEVANCE

In accordance with 42 C.F.R. §438.400, a grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, (1) quality of care or services provided, (2) aspects of interpersonal relationships such as rudeness of a provider or employee, (3) failure to respect the member's rights regardless of whether remedial action is requested, (4) right to dispute an extension of time proposed by the MCO to make an authorization decision and (5) request for disenrollment.

1.46 GRIEVANCE AND APPEALS SYSTEM

In accordance with 42 C.F.R. §438.400.,the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about grievances and appeals.

1.47 HABILITATION SERVICES

Health care services that help a person keep, learn or improve skills and functioning for daily

living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

1.48 HEALTH CARE ACQUIRED CONDITIONS

A medical condition or complication that a patient develops during a hospital stay, which was not present at admission. In most cases, hospitals can prevent HACs when they give care that research shows get the best results for most patients.

1.49 HEALTH CARE PROVIDER

In accordance with 29 CFR §825.125 a Health Care Provider means,

(1) A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or,

(2) Any other person determined by the Secretary to be capable of providing health care services.

1.50 HEALTH HOME

A health home provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes.

1.51 HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH) ACT

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

1.52 HEALTH INSURANCE

A type of insurance coverage that covers the cost of an insured individual's medical, behavioral and surgical expenses.

1.53 HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, protects health insurance coverage of workers and their families when they change or lose their jobs. HIPAA also requires the Secretary of the U.S. Department of Health and Human Services to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers.

1.54 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

1.55 HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT SECURITY RULE

The Health Insurance Portability and Accountability Act (HIPAA) Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

1.56 HEALTH PLAN, PLAN, OR HMO

Health Plan, Plan, or HMO means any organization that is licensed as a health maintenance organization ("HMO") by the Rhode Island Department of Business Regulation, and contracts with EOHHS to provide services pursuant to Title XIX and Title XXI of the Social Security Act to members.

1.57 HEALTH RISK ASSESSMENT

An assessment that is completed for all members through direct contact with the member, guardian, or adult caregiver.

1.58 HOME CARE SERVICES

Home Care Services means those services provided under a home care plan authorized by a

physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care and including, as authorized by a physician, physical therapy, occupational therapy, respiratory therapy, and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the member also needs personal care services. Home care services do not include respite care, relief care, or day care.

1.59 HOME HEALTH CARE

Home health care is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met. For patients recovering from surgery or illness, home care may include rehabilitative therapies.

1.60 HOME HEALTH SERVICES

Home Health Services are those services as defined in 42 C.F.R. §440.70.

1.61 HOSPICE SERVICES

Supportive services provided to patients who have reached the terminal stage of their illness when aggressive, curative therapy is no longer appropriate. Hospice care includes medical services such as pain management, as well as emotional support (for example, counseling) for both patients and their families.

1.62 HOSPITALIZATION

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

1.63 HOSPITAL OUTPATIENT CARE

Hospital outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

1.64 HOUSING STABILIZATION PROGRAM

A program that assists in preventing homelessness, sheltering those for whom homelessness is unavoidable, and rapidly re-housing the homeless in stable, permanent housing.

1.65 IBNR (INCURRED BUT NOT REPORTED)

IBNR means liability for services rendered for which claims have not been received.

1.66 INCENTIVE PAYMENTS

Incentive payment is a payment mechanism under which a qualifying Contractor receives additional funds above the capitation rate.

1.67 INDIAN

In accordance with 42 C.F.R. §438.14, an individual who meets the criteria contained in 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. §136.12 is:

(1) Is a member of a Federally recognized Indian tribe;

(2) Resides in an urban center and meets one (1) or more of the below four (4) criteria:

a. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

b. Is an Eskimo or Aleut or other Alaska Native;

c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

d. Is determined to be an Indian under regulations issued by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.68 INDIAN HEALTHCARE PROVIDER

In accordance with 42 C.F.R. §438.14 an Indian Healthcare provider is a health care program

operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. §1603).

1.69 INDIAN HEALTH PROGRAM

In accordance with 25 U.S.C. §1603(12) an Indian Health program is any health program administered directly by the IHS; any tribal health program; and any federally funded Indian tribe or tribal organization federally funded.

1.70 INTENSIVE CARE MANAGEMENT PLAN

An Intensive Care Management Plan is a written plan developed in collaboration with the member, the member's family (with written consent), guardian or adult caretaker, PCP and other providers involved with the member to delineate the Intensive Care Activities to be undertaken to address key issues of risk for the member that were identified in the course of the member's enrollment with the Contractor.

1.71 LIMITED ENGLISH PROFICIENT (LEP)

In accordance with 42 C.F.R. §438.10, limited English proficient means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English, may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.72 LONG-TERM SERVICES AND SUPPORT

In accordance with 42 C.F.R. §438.2, long-term services and support are services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

1.73 MARKETING

In accordance with 42 C.F.R. §438.104, marketing means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 C.F.R. §155.20, about qualified health plan.

1.74 MARKETING MATERIAL

In accordance with 42 C.F.R. §438.104, marketing manual means materials that:

(i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and

(ii) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees.

MCO, PIHP, PAHP, PCCM or PCCM entity include any of the entity's employees, network providers, agents, or contractors.

Private insurance does not include a qualified health plan, as defined in 45 C.F.R. §155.20.

1.75 MATERIAL ADJUSTMENT

In accordance with 42 C.F.R. § 438.2, material adjustment is an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

1.76 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE

The term "medical necessity", "medically necessary", or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms. For members under the age of 21, the term also includes the EPSDT services described in Section 1905(r) of the Social Security Act, including services necessary to correct or ameliorate a defect or physical or mental illness or condition discovered through EPSDT screenings.

A service is considered Medically Necessary if it is rendered for any of the following situations:

(1) Is provided in response to a life-threatening condition or pain;

(2) To treat an injury, illness or infection;

(3) To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;

(4) To provide care for a mother and child through the maternity period;

(5) To prevent the onset of a serious disease or illness;

(6) To treat a condition that could result in physical or behavioral health impairment; or,

(7) To achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity.

1.77 MEMBER OR MEDICAID MANAGED CARE MEMBER

Member means a Medicaid recipient enrolled in a Health Plan. The term member is used synonymously with the term "enrollee" or "beneficiary" in this Agreement.

1.78 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

MHPAEA requires managed care plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions.

1.79 NETWORK

The doctors, other health care providers, subcontractors and hospitals that a plan has contracted with to provide medical care to its members are a network. These providers are called "network providers" or "in-network providers."

1.80 NETWORK PROVIDER

In accordance with 42 C.F.R. §438.2, any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, or PAHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

1.81 NON-PARTICIPATING PHYSICIAN

Non-participating Physician means a physician licensed to practice that has not contracted with or is not employed by the Contractor to provide services under this Agreement.

1.82 NON-PARTICIPATING PROVIDER

Non-participating provider is a provider (doctor, hospital, pharmacy, etc.) that does not sign a contract to participate in the Contractor's provider network.

1.83 NON-RISK PAYMENT

In accordance with 42 C.F.R. §438.2, a non-risk payment is a type of risk mitigation strategy used to address uncertainty in rate development, a non-risk payment is a payment made to a managed care plan for specific, identifiable costs reimbursed outside of the capitation rate. This arrangement cedes complete risk for paying for certain services back to the state.

1.84 OVERPAYMENT

In accordance with 42 C.F.R. §438.2, an overpayment is a payment made to a Contractor or network provider to which the Contractor or provider is not entitled to under Title XIX of the Act.

1.85 PARTICIPATING PROVIDER

A provider who has contracted with the health plan to deliver medical/behavioral health services to covered persons. The provider may be a physician, hospital, pharmacy, other facility or other healthcare provider who has contractually accepted the terms and conditions set forth by the health plan. Also known as network or in-network provider.

1.86 PARTY

Party means either EOHHS or the Contractor in its capacity as a contracting party to this Agreement.

1.87 PATIENT CENTERED MEDICAL HOME

A Patient-Centered Medical Home (PCMH) provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. To be recognized as a PCMH, a practice must meet the three-part definition established by the Office of the Health Insurance Commissioner (OHIC), which requires demonstration of practice transformation, implementation of cost management initiatives, and clinical improvement. Updated definitions, standards, quality measures, and an updated list of recognized practices can be found at the following link; http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php

1.88 PEER NAVIGATOR

Peer Navigators are paraprofessionals with specialized training. Peer Navigators have a personal experience in special health care needs and chronic or complex illness. Peer Navigators engage with members in the home and community providing person centered, culturally sensitive support building on the values, strengths and preferences of the member.

1.89 PHYSICIAN SERVICES

Physician services are health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

1.90 PLAN

A plan is a benefit provided to an individual by an employer, union or other group sponsor that pays for a portion or all their health care services.

1.91 PLAN OF CARE

The Plan of Care is a written plan developed in collaboration with the member, the member's family (with written consent), guardian or adult caretaker, PCP and other providers involved with the member to delineate the Intensive Care Activities to be undertaken to address key issues of risk for the member.

1.92 PLAN PHYSICIAN OR PARTICIPATING PHYSICIAN

Plan physician or participating physician means a physician licensed to practice in Rhode Island who has contracted with or is employed by the Contractor to furnish services covered in this Agreement.

1.93 POST-STABILIZATION CARE SERVICES

In accordance with 42 C.F.R. §438.114 covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.

1.94 POTENTIAL ENROLLEE

In accordance with 42 C.F.R. § 438.2, a Medicaid eligible RIte Care, Rhody Health Partners, or an ACA Adult Expansion population individual who has not yet been enrolled by the Contractor.

1.95 PRE-AUTHORIZATION, PRIOR AUTHORIZATION OR PRECERTIFICATION

Pre-authorization, Prior Authorization, or Precertification means a health plan's determination that a proposed health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary to meet the needs of the member.

1.96 PREMIUM

Premium is the amount an individual must pay for their health insurance every month. In addition to a premium, an individual must pay other costs for their health care, including a deductible, copayments, and coinsurance.

1.97 PREPAID BENEFIT PACKAGE

Prepaid Benefit Package means the set of health care-related services for which Health Plans will be responsible to provide and for which the Health Plan will receive reimbursement through a per member per month pre-determined capitation rate.

1.98 PREPAID INPATIENT HEALTH PLAN

In accordance with 42 C.F.R. §438.2, a prepaid inpatient health plan is an entity that:

(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

1.99 PRESCRIPTION DRUG COVERAGE

Health insurance or plan that helps pay for prescription drugs and medications.

1.100 PRESCRIPTION DRUGS

Drugs and medications that, by law, require a prescription.

1.101 PREVALENT

In accordance with 42 C.F.R. §438.10 prevalent means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient

1.102 PRIMARY CARE

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, obstetrician/gynecologist, geriatric physician or other medical specialists, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

1.103 PRIMARY CARE PROVIDER (PCP)

Primary Care Provider (PCP) is a class of physicians that typically includes family and general practice, pediatrics, gynecology, internal medicine, geriatrics, or other medical specialists who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who are prepared to undertake the responsibilities of serving as a PCP as stipulated in the Contractor's primary care agreements. As PCPs, these physicians may control access that managed care plan members have to other plan services such as diagnostic testing or visits to specialists. Primary Care Providers also will meet the credentialing criteria established by the Contractor and approved by EOHHS. NCQA certified Patient Centered Medical Homes will be included in the Contractor's network as a primary care provider. The Primary Care Provider may designate other participating plan clinicians who can provide or authorize a member's care.

1.104 PRIVATE DUTY NURSING

In accordance with 42 C.F.R. § 440.80 private duty nursing services means nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the beneficiary's physician; and

(c) To a beneficiary in one or more of the following locations at the option of the State -

(1) His or her own home;

(2) A hospital; or

(3) A skilled nursing facility.

1.105 PROVIDER

In accordance with 42 C.F.R. § 438.2, provider means an individual or entity including physicians, nurse practitioners, physician assistants and others that are engaged in the delivery of medical/behavioral health care services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

1.106 PROVIDER PREVENTABLE CONDITIONS

Provider-preventable condition means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this section. Health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a HAC in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Other provider-preventable condition means a condition occurring in any health care setting that meets the following criteria: (1) Is identified in the State plan, (2) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, (3) Has a negative consequence for the beneficiary, (4) Is auditable, and (5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

1.107 RATE CELL

In accordance with 42 C.F.R. §438.2 rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for purpose of determining the capitation rate.

1.108 RATING PERIOD

In accordance with 42 C.F.R. § 438.2 rating period means a period of twelve (12) months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification.

1.109 READILY ACCESSIBLE

Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act.

1.110 REHABILITATIVE SERVICES

In accordance with 42 C.F.R. §440.130, except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

1.111 RELATED GROUPS

Related Groups mean those groups the Contractor must make coverage available to, although they are outside of the actual program.

1.112 RHODY HEALTH PARTNERS

Rhody Health Partners (RHP) is the name of the comprehensive Medicaid Managed Care delivery system option for Medicaid-eligible adults who meet specified eligibility criteria for Rhody Health Partners, as designated by EOHHS.

1.113 RHODY HEALTH PARTNERS ELIGIBLE

Rhody Health Partners eligible mean those Title XIX eligible groups described herein.

1.114 RISK CONTRACT

In accordance with 42 C.F.R. §438.2 a risk contract means an agreement under which the Contractor assumes financial risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the agreement.

1.115 RISK CORRIDOR

In accordance with 42 C.F.R. §438.6 risk corridor means a risk sharing mechanism in which the State and the Contractor may share in profits and losses under the contract outside of the threshold amount.

1.116 RITE CARE

RIte Care is the health care delivery program through which the State of Rhode Island serves the RI Works and RI Works-related portions of its Title XIX (Medicaid) population, uninsured pregnant women and children under age nineteen living in households that meet specified eligibility criteria, and other specific eligible populations as designated by the State.

1.117 RITE CARE ELIGIBLES

RIte Care eligibles mean those Title XIX eligible groups described herein.

1.118 RITE SHARE

RIte Share is the premium assistance program created and operated under Chapter 40-8.4-12 et seq. of the Rhode Island General Laws and the amended state plan under Title XIX (Medicaid) for the State of Rhode Island pursuant to which EOHHS will purchase employer-sponsored health insurance for RIte Care Eligible low-income working individuals and their families who are eligible for employer-sponsored insurance but could not otherwise afford such insurance.

1.119 RITE SHARE MEMBER

RIte Share member means a Medicaid-eligible person who is enrolled in an employer-sponsored health benefit plan.

1.120 SHORT-TERM CARE MANAGEMENT

Short-Term Care Management represents those actions taken by the Contractor necessary to address the needs for continuity and access to services that have been identified for the member in the Health Risk Assessment or in the course of a member's enrollment with the Contractor.

1.121 SIBLING

Sibling includes sisters, brothers, half-sisters, half-brothers, adoptive sisters, adoptive brothers, step-sisters and step-brothers living in the same household.

1.122 SKILLED NURSING CARE AND SKILLED CARE SERVICES

They are services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

1.123 SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

1.124 SSI

SSI means Supplemental Security Income, or Title XVI of the Social Security Act.

1.125 STABILIZED

In accordance with 42 C.F.R. §438.114 (citing 42 C.F.R. §489.24) an "emergency medical condition" means that that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or an emergency medical condition in the context of child birth that the woman has delivered the child and the placenta.

1.126 STATE

State means the State of Rhode Island, acting by and through the Executive Office of Health and Human Services, or its designee.

1.127 STATE FAIR HEARING

In accordance with 42 C.F.R. §438.400 and the EOHHS appeal hearing process contained in the 210-RICR-10-05-02 for EOHHS Appeals Process and Procedures for EOHHS Agencies and Program.

1.128 SUBCONTRACTOR

In accordance with 42 C.F.R. §438.2 an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

1.129 SUSPENSION

Suspension means items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State or local court will not be reimbursed under Medicaid.

1.130 TELEHEALTH

The Health Resources Services Administration defines telehealth as the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, public health and health administration.

1.131 TOTAL COST OF CARE (TCOC)

Total cost of care (TCOC) is a fundamental element the Accountable Entity program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify a potential shared savings or risk pool. Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics.

1.132 UNINSURED

Uninsured means any individual who has no coverage for payment of health care costs either through a private organization or public program.

1.133 URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

1.134 URGENT MEDICAL CONDITION

Urgent Medical Condition means a medical (physical or mental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in:

Placing the patient's health in serious jeopardy;
Serious impairment to bodily function; or
Serious dysfunction of any bodily organ or part.

1.135 WASTE

The overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system.

1.136 WITHHOLD ARRANGEMENT

Withhold arrangement means any payment mechanism under which a portion of a capitation rate is withheld from the Contractor and a portion or all the withheld amount will be paid to the Contractor for meeting targets specified in the contract.

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

2.01 GENERAL

This article describes the operational and financial standards with which the Contractor must comply in full. The standards have been set to allow plans flexibility in their approach to meeting Medicaid Managed Care program objectives, while ensuring that the special needs of these populations are addressed. EOHHS and the Contractor will work collaboratively to build a successful program that will achieve the state goals and requirements of EOHHS. EOHHS and the Contractor will engage in a planning period initiating at the start of this contract to address opportunities for program improvements.

EOHHS agrees to purchase, and the Contractor agrees to fulfill all requirements and to furnish or arrange for the delivery of the scope of services as specified in this Article.

In return for Capitation Payments, the Contractor agrees to provide eligible members with the medical care and services described in this ARTICLE II: HEALTH PLAN PROGRAM STANDARDS and subsequent Attachments hereto, subject to any stop-loss provisions.

The Contractor will furnish or arrange for the personnel, facilities, equipment, supplies, pharmaceuticals, and other items and expertise necessary for, or incidental to, the provision of medical care services specified below, at locations including, but not limited to, the entire State of Rhode Island, to members enrolled with the Contractor.

In accordance with 42 CFR 438.6[i], the Contractor will provide or arrange for the provision of Covered Services under this Comprehensive Risk Contract. The Contractor's legal responsibility to EOHHS is to assure that all activities specified in this contract are carried out and will not be altered if a service is arranged by the Contractor or provided by a subcontractor.

Due to the movement towards accountable care and value-based purchasing, EOHHS requires that the Contractor will work towards incorporating value-based purchasing initiatives into their provider contracts. The Contractor will support healthcare providers to improve performance. Contractors will hold healthcare providers accountable for the cost, quality of care, and outcomes. The Contractor will support healthcare providers to engage patients in determining plan of care, and work to make healthcare s proactive rather than reactive. EOHHS is committed to creating partnerships with organizations using accountable care delivery models that integrate medical care, behavioral health, substance use disorders, community health, public health, social determinants, related social services, and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

Pursuant to the development of accountable care delivery models for each period, the Contractor will meet or exceed the requirements set forth in Section 2.01.01 for the percent of their total payments made to providers using EOHHS approved alternative payment methods and EOHHS has formally initiated a process for EOHHS certification of qualified Accountable Entities.

EOHHS anticipates that over time such arrangements with Accountable Entities will become an increasingly important component of its contracting requirements for managed care programs and that in the future the level of contracting with Accountable Entities will be a factor in State assignment of members to health plans. The Contractor is responsible for implementing their AE programs in conformance with guidance issued or to be issued by EOHHS on issues like attribution and total cost of care. All total cost of care calculation methodologies must be approved by EOHHS.

As part of CFR 42 CFR 438.6, the State has the authority to implement incentive payments to providers. Contingent upon CMS approval, the State anticipates the implementation of hospital and nursing home incentive payments on a pre-determined schedule as defined by EOHHS. Payment are to be made in the current contract period based on performance by the specified providers in fiscal year 2016. These incentive payments are not being considered part of the medical component of the premium payment made to the Health Plan but will be paid directly by EOHHS to the Contractor. Total incentive payment inclusive of performance goal and/other provider performance-based payments cannot exceed five percent of capitation.

2.01.01 Alternative Payment Methodologies (APMs), Health System Transformation Project (HSTP), and Accountable Entities (AEs)

Throughout sections 2.01.01.01 and 2.01.01.02, there are provisions which are conditionally effective and are so indicated. The condition will be related to the Contractor's total RI Medicaid product beneficiaries and the opportunity for AEs to reach minimum attributed lives from this Contractor. As such, the Contractor will not be obligated to comply with the indicated provisions until total RI Medicaid membership is at or exceeds 10,000 beneficiaries. Upon reaching 10,000 beneficiaries, the Contractor will be required to subcontract with at least one EOHHS certified Accountable Entity which has at least 2,000 attributed lives. This requirement expands to subcontracts with two Accountable entities covering at least 10,000 lives when overall membership reaches 25,000.

The Contractor will provide EOHHS with a monthly report on overall RI Medicaid membership and membership in subcontracted AEs. Once both minimum thresholds have been reached, conditionally effective provisions will become effective on the next July 1 and be considered as the start to Contract Period 1.

Through this Agreement EOHHS is advancing two key programmatic objectives. One is transitioning away from fee-for-service payment models through progressive development of value based Alternative Payment Models that incorporate total cost of care and quality performance for an attributed population. The second is promoting the development of EOHHS certified Accountable Entities that are inter-disciplinary in composition and practice, and focused on population health, with programs tailored to address varying levels and types of needs. These two objectives are central elements of EOHHS's Health System Transformation Project and are incorporated as central requirements within this Agreement. The Contractor is required to meet targets for Alternative Payment Methodologies as set forth in Section 2.01.01.01, Alternative Payment Methodologies.

The Contractor is required to enter into contracts with EOHHS certified AEs as set forth in Section 2.01.01 (Alternative Payment Methodologies (APMs), Health System Transformation Project (HSTP), and Accountable Entities (AEs) and in Section 2.08.02 ("Contacting with EOHHS Certified Accountable Entities. Additionally, EOHHS has received approval for implementation of the Health System Transformation Project (HSTP). The HSTP is intended to be developed within, and in partnership with, MCO contractors and provides for incentive funds to support (a) the design, development, and implementation of AE infrastructure, skills and capacity and (b) MCO performance in implementation of the AE-MCO contractual partnerships. Incentive based funding opportunities through HSTP begin upon EOHHS certification of an AE and execution of an EOHHS compliant total cost of care and attribution-based contract with an AE. In the event that the requirements of Section 2.08.02 are not met, EOHHS may reduce capitation payments as set forth in Section 2.08.02 and will pursue alternative pathways to providing HSTP related incentive funds to EOHHS certified AEs.

2.01.01.01 Alternative Payment Methodologies

As a core objective of this Agreement EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with Alternative Payment Methodologies that provide incentives for better quality, outcomes and more efficient delivery of health services

EOHHS requires that the Contractor progressively incorporate value based Alternative Payment Methodologies into their contracts with providers. Within this framework primary emphasis is given to total cost of care arrangements with EOHHS certified Accountable Entities.

EOHHS is committed to development of partnerships between health plans and provider based organizations using accountable care delivery models that integrate medical care, behavioral health, substance use disorders, community health, public health, social determinants, related social services, and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

For each contract period, the Contractor will meet or exceed the requirements set forth Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners for the percent of their total payments made to providers using EOHHS approved alternative payment methods. APM contracts may not include the delegation of network contracting, provider payment, and/or claims processes, member services, or grievance and appeals functions without the express written consent of EOHHS. For any other function (e.g. care management) that is delegated, the Contractor must have an established process for assessing the capability of the subcontractor to assume responsibility for the delegated function(s) and have an established policy and procedure for overseeing performance of such function(s). The Contractor must have a written plan for its monitoring and oversight of the performance of all contracts with providers using APMs. Such oversight will include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice. Upon request by EOHHS, the Contractor will submit an electronic copy of its written plan for monitoring and oversight of

all APM subcontractors.

The Contractor is required to develop and implement subcontracts with providers including Alternative Payment Methodologies as set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners. This document sets forth the requirements of the Rhode Island Executive Office of Health and Human Services (EOHHS) for managed care organizations contracted with EOHHS as Medicaid Managed Care Organizations (MCOs).

For contracts with entities certified as comprehensive Accountable Entities, subcontracts between the health plan and the certified AE will be in compliance Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners for the applicable time period.

The Contractor's compliance with these requirements pertains to the applicable type of certified AE and the applicable time period (e.g., the Contract Period).

EOHHS will review the Contractor's Accountable Entity contract to assure compliance with requirements before granting approval. Transparency in such arrangements is required in conformance with 42 C.F.R § 438.6[i]. Based on 42 C.F.R. § 436.6(g), any Contractor/AE risk arrangements must stipulate that the EOHHS and the DHHS may inspect and audit any financial records of the Contractor or its subcontractors. Any physician incentive plans must comply with the requirements in 42 C.F.R. § 438.3(i), § 422.208" and § 422.210.

In order to align with the state fiscal year, beginning January 1, 2018, all contracts with AEs will have a performance period that ends on June 30. All total cost of care calculations will be based on a performance period ending June 30.

MCOs are required to participate in primary care capitation policy, planning, and design processes led by OHIC and EOHHS and leveraging the technical expertise of contractors, including but not limited to Bailit Health and CTC-RI. Participation shall include attendance at relevant meetings, providing requested data, financial analysis, design preferences, and any other such effort to support the development of both financial and clinical models to enable implementation of primary care capitation.

The MCO shall also simulate practice revenues under the designed model to test the efficacy of the model per guidance from EOHHS.

2.01.01.01.01 Capitation Withhold and Adjusting Payments

Effective July 1, 2018 EOHHS will withhold 0.5% of monthly capitation amounts. EOHHS will consider the withhold, for the prorated period of July 1, 2018 through December 31, 2018, as earned due to the Contractor's efforts in advancing the development of APMs. The withheld amounts will be repaid as quarterly adjusting payments subject to the Contractor's demonstration that it has achieved the threshold values in APM payments for the reporting period as set forth in Section 2.01.01.01.02 (Alternative Payment Methodology for Each Contract Period). Such demonstration will be on the basis of quarterly submissions of the "Alternative Payment

Methodology Reporting Template for Managed Care Organizations" (included as ATTACHMENT D to Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners and EOHHS review of the submitted report. If the Contractor does not achieve the threshold value within the prescribed period, EOHHS will consider the amount forfeited and retained accordingly. Quarterly submissions and adjusting payments will be based on cumulative performance for the Contract Period.

The Contractor submissions to EOHHS for "Alternative Payment Methodology Reporting Template for Managed Care Organizations" will be done in accordance with timeline on Reporting Calendar. EOHHS will review the report within thirty (30) days of receipt of the report. Based on review by EOHHS of the completeness and accuracy of the report adjusting payments to the Contractor within forty-five (45) days of receipt of the report.

2.01.01.02 Accountable Entities

EOHHS has actively pursued the development of certified Accountable Entities, notably through development of the Health System Transformation Project as approved by CMS. The Contractor is required to enter into contracts with EOHHS certified AEs. The specific contracting requirements are set forth in Sections 2.01.01 and 2.08.02.

All provisions in this contract pertaining to EOHHS certified Accountable Entities apply to EOHHS certification for certified Comprehensive Accountable Entities. All agreements will be in compliance with EOHHS requirements as set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners including:

- Attribution requirements
- APM/Total Cost of Care (TCOC) requirements, including quality component and Provisions regarding downside risk
- Incentive Program requirements

During the term of this Agreement EOHHS compliant arrangements with AEs will become an increasingly important component of the Contractor's contracting requirements. As applicable to the eligible populations, the Contractor's algorithm for PCP assignment for persons not selecting a PCP must include an EOHHS approved factor for prioritizing PCP assignment to EOHHS certified AEs as set forth in Section 2.05.07 of this amended contract, "Assignment of Primary Care Providers".

2.02 LICENSURE AND ACCREDITATION

The Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 27-41, "the HMO Act" or that it will become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Business Regulation prior to signing an Agreement with EOHHS. If the Contractor is not a licensed HMO in Rhode Island, the Contractor certifies that it is either a nonprofit hospital

service corporation that is licensed by the Rhode Island Department of Business Regulation ("DBR") under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR, and that it meets the following requirements:

Meets the requirements under 27-18.9-8, External Appeal Procedural Requirements only of the Benefit Determination and Utilization Review Act.

- Is accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid Managed Care organization or otherwise for a newly entering plan:
    - The Contractor must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid Managed Care organization in another State and;
    - The Contractor must submit a specific timeline outlining the Contractor's plan to achieve full accreditation within twelve months of the execution of the contract and;
    - Failure to obtain accreditation by the date specified will result in the suspension of enrollment.

- Is certified by a nationally known health utilization management organization.

- Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount. It is suggested the Contractor obtain NCQA distinction in Multicultural Health Care.

Achievement of provisional accreditation status will require a corrective action plan within thirty (30) calendar days of receipt of the Final Report from the NCQA and may result in termination of the State's Agreement with the Contractor. In the event that NCQA were to deny accreditation to the Contractor, EOHHS will consider this to be cause for termination of the Agreement.

Contractor agrees to notify EOHHS, within thirty (30) days, of any complaint, investigation, disciplinary action, or other compliance review initiated or issued to the Contractor by a federal or state government agency or other regulatory body. The Contractor also agrees to forward to EOHHS a copy of any correspondence sent by the Contractor to the Rhode Island Department of Business Regulation which pertains to the Contractor's licensure or its contract status with any institution or provider group.

The Contractor agrees to provide to EOHHS, or its designees, any information requested pertaining to its licensure, and/or accreditation including communication to and from the NCQA. Such information will include any communications pertaining to the Contractor's accreditation by NCQA as well as actual Healthcare Effectiveness Data and Information System (HEDIS)® and Consumer Assessment of Healthcare Providers & Systems (CAHPS)® data, transmittals, and reports.

The Contractor must authorize any private independent accrediting entity to provide EOHHS with a copy of the Contractor's most recent accreditation review including the expiration date of the accreditation, accreditation status, survey type and level, as applicable, along with any recommended actions or improvements, corrective action plans and summaries of findings.

2.03 HEALTH PLAN ADMINISTRATION

The Contractor agrees to maintain sufficient administrative staff and organizational components to comply with all program standards described herein. At a minimum, the Contractor agrees to include each of the functions noted herein. The Contractor agrees to staff qualified persons in numbers appropriate to its size of enrollment.

The Contractor may combine functions or split the responsibility for a function across multiple departments, if it can demonstrate that the duties of the function are being carried out. Similarly, the Contractor may contract with a third party (subcontractor) to perform one or more of these functions, subject to the subcontractor conditions described in this Agreement.

2.03.01 Executive Management

The Contractor agrees to have an executive management function with clear authority over all the administrative functions noted herein.

2.03.02 Other Administrative Components

The Contractor must include each of the administrative functions listed below, with the duties of these functions conforming to the program standards described in this chapter. The required functions are:

- Medical Director's Office
- Accounting and Budgeting Function
- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function
- Claims Processing Function
- Management Information System
- Program Integrity and Compliance
- Privacy and Security Officer

2.03.03 RI Works Participants

The State operates a worker training and employment assistance program known as the RI Works. As part of its hiring practices, the Contractor agrees to consider qualified RI Works individuals for openings. For its part, the State is prepared to design and implement training programs for RI Works individuals to provide them with the skill sets required by Rhode Island employers, particularly those with government contracts. The Contractor agrees to make good faith efforts to fill at least fifty percent (50%) of their new or open positions related to this Agreement with RI Works participants, providing they are qualified for the positions.

2.03.04 Contract Readiness Review Requirements

EOHHS, or their designee, will conduct a Readiness Review of the Contractor, which must be completed successfully, as determined by EOHHS, prior to the Contract Operational Start Date.

2.03.04.01 EOHHS Readiness Review Responsibilities

EOHHS or its designee will conduct a Readiness Review of the Contractor that will include, at a minimum, one on-site review. This review will be conducted prior to marketing to and enrollment of eligible beneficiaries into the Contractor. EOHHS or its designee will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

- Network provider composition and access;
- Staffing, including key personnel and functions directly impacting Enrollees;
- Capabilities of First Tier, Downstream and Related Entities;
- Content of Health Care Provider Contracts, including any provider performance incentives;
- Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities);
- Comprehensiveness of quality management/quality improvement and Utilization Management strategies;
- Internal Grievance and Appeal policies and procedures;
- Fraud and abuse and program integrity policies and procedures;

- Financial solvency; and
- Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data.

No individual will be enrolled into the Contractor's MCO until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

EOHHS or their designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the Contract Operational Start Date.

EOHHS may, at its discretion, postpone the Contract Operational Start Date for the Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and EOHHS do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract pursuant to this Contract.

The Contractor must demonstrate to EOHHS' satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing.

The Contractor must provide EOHHS, or their designee, with corrections requested by the Readiness Review.

2.04 ELIGIBILITY AND PROGRAM ENROLLMENT

2.04.01 RIte Care Eligible Groups

As specified in 42 CFR 438.56(b)(2)(3), the Contractor will not act to discriminate among enrollees based on their health status or heath care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicated probable need for substantial future medical services. The Contractor will ensure that members are free to exercise their rights without adverse treatment by the Contractor or any of it delegated entities or contracted providers.

2.04.01.01 Five Base RIte Care Eligible Groups

The RIte Care population consists of five (5) different eligible groups, or aid categories (the defined groups represent a consolidation of various aid categories). Qualification for the program is based on a combination of factors; including family composition, income level, insurance status,

and/or pregnancy status, depending on the aid category. The scope of benefits, program cost-sharing options/requirements and enrollment procedures vary by aid category and are described herein.

2.04.01.01.01 Eligibility of Families

This aid category consists of persons eligible for Medicaid based on RI Works or RI Works-related status or based on families with minor child or children less than eighteen with income specified by the State.

2.04.01.01.02 Eligibility of Children Under Nineteen Years of Age Under 250 Percent of the FPL

This aid category consists of children under nineteen (19) years of age living in families and whose income is under two hundred fifty percent (250%) of the FPL.

2.04.01.01.03 Eligibility of Pregnant Women Under 250 Percent of the FPL ("SOBRA-Extension Group")

This aid category consists of uninsured pregnant women living in families under two hundred fifty percent (250%) of the FPL. The category is referred to as the "SOBRA-Extension Group" (Sixth Omnibus Budget Reconciliation Act). The group is eligible for the full scope of Medicaid benefits, as described below, through delivery and two months post-partum.

2.04.01.01.04 Eligibility of Extended Family Planning Group

This aid category consists of women who meet the following criteria: have qualified for RIte Care; were pregnant and are now sixty (60) days postpartum or sixty (60) days post-loss of pregnancy; and are subject to losing eligibility for Medicaid. The group is eligible to receive a schedule of family planning-related benefits for up to twenty-four (24) months, as described in ATTACHMENT F. Persons who qualify for this benefit remain with the same Health Plan they selected or to which they were assigned for comprehensive health service delivery.

2.04.01.01.05 Eligibility of Children with Special Health Care Needs

This category includes: (1) blind/disabled individuals up to age 21 eligible for Medicaid based on SSI; (2) children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children) up to age 19; (3) individuals up to age 21 receiving subsidized adoption assistance; (4) children in substitute care ("foster care"). Enrollment in RIte Care for these children will be based on EOHHS determination of managed care eligibility; and (5) adults age 21-26 who were previously active with the Department of Youth and Family Services (DCYF) and do not have

other comprehensive coverage and (6) youths who opt to remain in the care of DCYF up to age 21 if they entered foster care on or after their 16th birthday and did not achieve permanency (i.e. adopted, reunified, etc.) and were set to age out of foster care. Children and youth eligible on the basis of their participation in a DCYF foster care, kinship or guardian program whether in a home-based, residential or institutional setting, as applicable.

2.04.01.02 Three Related Groups

In addition to the five RIte Care eligible groups, there are three (3) additional groups, described below that the Contractor must make coverage available to as part of the Rite Care program, as described below.

2.04.01.02.01 Eligibility of Conversion Group

This group consists of RIte Care Health Plan members who have lost their eligibility for the program. It also includes individuals who are eligible for the Extended Family Planning Benefits described herein.

2.04.01.02.02 Uninsured Children Up to Age Eighteen Above 250 Percent of the FPL

This group consists of children up to age eighteen living in families who are uninsured and whose income is above two hundred fifty percent (250%) of the FPL

2.04.01.02.03 Other Medicaid Clients in RIte Care Households

In household situations where one or more members are enrolled in the plan through RIte Care, EOHHS may request that the Contractor offer optional enrollment to all other household members who qualify for Medicaid. The Contractor would only be requested to offer such enrollment during the initial enrollment and subsequent open enrollment periods. EOHHS will provide reimbursement for these members on a fee-for-service basis in accordance with the Medicaid fee schedule.

2.04.02 RIte Care Health Plan Lock-In

Following the ninety (90) days after their initial enrollment into a Health Plan, Rite Care members will be restricted to that Health Plan until the next open enrollment period, unless disenrolled under one of the conditions described in "Reasons for Disenrollment" herein.

2.04.03 RIte Care Guaranteed Eligibility

There are no eligibility guarantees for Rite Care members.

2.04.04 Rhody Health Partners Eligible Groups

Eligibility for enrollment in Rhody Health Partners is based on EOHHS determination of Medicaid beneficiaries who meet the following criteria: (1) age twenty-one (21) and older; (2) categorically eligible for Medicaid; (3) not covered by other third-party health insurance (including Medicare); (4) residents of Rhode Island; and (5) individuals not residing in an institutional facility for greater than thirty (30) days. Enrollment in Rhody Health Partners will be based on EOHHS' sole determination of eligibility for enrollment in Rhody Health Partners.

2.04.05 Rhody Health Partners Eligible Determination

EOHHS will have sole authority for determining whether individuals meet the eligibility criteria specified and therefore are eligible to enroll in a Rhody Health Partners Health Plan, and for determining the individual's premium rate category.

2.04.06 Rhody Health Partners Guaranteed Eligibility

There are no eligibility guarantees for Rhody Health Partners members.

2.04.07 Rhody Health Partners Health Plan Lock-In

Following the ninety (90) days after their initial enrollment into a Health Plan, Rhody Health Partners members will be restricted to that Health Plan until the next open enrollment period, unless disenrolled under one of the conditions described in "Reasons for Disenrollment" herein.

2.04.08 Affordable Care Act Eligible Population

The Affordable Care Act expands the Medicaid eligibility for specific population groups. The Contractor will cover, under this Agreement, adults who are between the ages of age nineteen (19) and sixty-four (64), who are at or below the Federal Poverty Level based on household income, using the application of a modified adjusted gross income (MAGI), who are not pregnant, who otherwise do not qualify for Medicaid, and are not eligible for or enrolled in Medicare

2.04.08.01 Eligibility Determination

EOHHS will have sole authority for determining whether individuals or families meet any of the eligibility criteria and therefore are eligible to enroll in a Health Plan.

2.04.08.02 Guaranteed Eligibility

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through two months postpartum or post loss of pregnancy and then are eligible for an Extended Family Planning benefit for up to an additional twenty-four months.

2.04.09 New Eligibility Groups

EOHHS reserves the right to add new eligibility groups at any time. EOHHS' intent to add any new eligibility group and the terms upon which any new eligibility would be covered under this Agreement will be made according to the notice provisions of the Agreement. The Contractor will have forty-five (45) calendar days from the date of receipt of such notice to either accept or reject in writing the addition of the new eligibility group(s) and the terms proposed. Acceptance will be formalized through an amendment to this Agreement, as provided in ARTICLE III: CONTRACT TERMS AND CONDITIONS.

2.04.10 Non-Biased Enrollment Counseling

At the time of initial eligibility determination or re-certification, EOHHS will make available non-biased enrollment counseling to eligible persons who are not already enrolled in a Health Plan. Responsibilities of the counselors include the following:

- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about managed care in general, including: the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the Primary Care Provider (PCP); and the responsibilities of the Health Plan member.

- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about benefits available through the Contractor's Health Plan, both in-plan and out-of-plan.

- Informing the Potential Enrollee and his or her family, guardian or adult caregiver of available Health Plans and outlining criteria that might be important when making a choice, e.g., presence or absence of an existing PCP or other providers in a Health Plan's network.

The Contractor will provide updated materials to EOHHS annually to facilitate enrollment counseling. All informational materials related to members and potential members must be written at no higher than a sixth-grade level, in a format and manner that is easily understood.

2.04.11 Voluntary Selection of Health Plan by Members

At the time of application or at other times determined in its sole discretion by EOHHS, applicants or beneficiaries will be offered the opportunity to select a Health Plan or another program option, if applicable. In accordance with 42 CFR 438.54, beneficiary's enrollment in a Health Plan is voluntary. If an eligible member does not select a Health Plan or does not select another program option, he or she will automatically be assigned to a Health Plan. This process does not apply to periods designated for open enrollment.

2.04.12 Automatic Assignment to Health Plans

In accordance with 42 C.F.R. §438.54, EOHHS shall employ a formula, or algorithm deemed by EOHHS to be in the best interests of the members that may include quality metrics, Health Plan performance of contract requirements including but not limited to contracting with EOHHS certified AEs, Health Plan financial performance, or other considerations to assign any eligible member that does not make a voluntary selection.

2.04.13 Automatic Re-Assignment Following Resumption of Eligibility

Members who are disenrolled from a Health Plan, due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment, may select a Health Plan of their choice. Member who do not make a Health Plan selection will be automatically re-enrolled, or assigned, into their previous Health Plan upon reinstatement of their Medicaid eligibility. If more than sixty (60) calendar days have elapsed and the Medicaid member does not make a Health Plan selection at the time eligibility was reinstated, the member will be auto-assigned to a Health Plan based on EOHHS' algorithm referenced in Section 2.04.12

2.05 MEMBER ENROLLMENT AND DISENROLLMENT

2.05.01 Health Plan Marketing

The Contractor is required to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing for open enrollment periods that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. Member materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS. The Contractor is required to use RI EOHHS Model Member Handbook and Appeals/Grievances Notification Model Documents. Contractors are required to add MCO specific language to Model Documents. EOHHS requires the review and prior approval of all materials related to or containing information that is intended to be used for education, outreach or marketing purposes for MCO enrollees or prospective enrollees. Contractors are required to comply with the information

requirements and marketing guidelines under 42 C.F.R. Section 438.10 and 438.104; 2019 EOHHS Marketing Guidelines For Marketing and Member Communications and Marketing requirements set forth in the CMS Medicaid and CHIP Final Rule. The Contractor agrees to submit marketing strategy and plans if requested.

The Contractor may conduct marketing campaigns for members subject to the restrictions noted in *Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs.* The Contractor agrees not to display or distribute marketing materials, nor solicit members in any other manner, within fifty feet of eligibility and enrollment offices unless it has received permission to do so from EOHHS.

The Contractor agrees to develop member materials that comply with 42 CFR 438.104**Error! Bookmark not defined.** and *Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs.* Written material must use easily understood language and format and satisfy all the requirements provided for in 42 CFR 438.10. In accordance with 42 CFR 438.104(b)(2)(i), the Contractors may not communicate, either in writing or orally, any statements that enrollees must enroll in the Health Plan to obtain benefits or to not lose benefits. The Contractor may not communicate, either in writing or orally to enrollees that CMS, the Federal or State government or similar entity endorse the Contractor. All written material must be written at no higher than a sixth-grade level. Written material must be available in alternative formats (e.g. audio and large print) and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State which include: (1) Spanish, (2) Portuguese, (3) Chinese, (4) French Creole (Haitian Creole), (5) Mon-Khmer/Cambodian, (6) French, (7) Italian, (8) Laotian, (9) Arabic, (10) Russian, (11) Vietnamese, (12) Kru (Bassa), (13) Ibo, (14) Yoruba*, and (15) Polish. Taglines must be written in large print which is defined as conspicuously visible, that explains the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). The Contractor must make auxiliary aids such as TTY/TDY and American Sign Language, available to potential members and members with disabilities free of charge as required by 42 CFR 438.10(d)(4). All potential enrollees and members must be informed that information is available in alternative formats and how to access those formats. However, such alternative media will not be a substitute for the requirement that the Contractor provide all members with a written member handbook except for those members with special needs that warrant an alternative format. Materials will be available in alternate languages for those members with limited or no English proficiency. The State will determine whether the Contractor's marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104**Error! Bookmark not defined.**.

The Contractor, through members of its outreach staff and provider network, is encouraged to identify uninsured patients who may be Medicaid eligible and to make appropriate referrals to the appropriate contacts such as navigators, DHS and Healthsource RI to assist in determining eligibility for Medicaid programs.

When engaged in marketing its programs or in marketing targeted to potential or current members, the Contractor: (1) will not distribute marketing materials to less than the entire service area; (2) will not distribute marketing materials without the approval of EOHHS; (3) will not seek to influence enrollment in the Health Plan in conjunction with the sale or offering of private insurance; and (4) will not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities. The Contractor may provide information electronically to members if the following conditions are satisfied:

- The information is in a format that is readily accessible.
- The information is in a location on the Contractor's website that is prominent and readily accessible.
- The information is provided in an electronic form which can be electronically retained and printed.
- The information is consistent with content and language requirements.
- The Contractor notifies the enrollee that the information is available in paper form without charge upon request.
- The Contractor provides, upon request, information in paper form within five (5) business days.

2.05.02 Health Plan Enrollment Procedures

EOHHS will conduct enrollment activities for eligible individuals under this Agreement. EOHHS will conduct an annual open enrollment.

EOHHS will supply the Contractor with a list of members newly enrolled into the Health Plan, as discussed in Section 2.05.04 below.

EOHHS will supply the Contractor on a daily basis for RIte Care members and on a monthly basis for Rhody Health Partners and ACA Adult Expansion members, with a list of members newly enrolled into the Health Plan, as discussed in Section 2.05.04 below. The Contractor agrees to accept enrollment information in the data format submitted by EOHHS.

The Contractor agrees to have written policies and procedures for enrolling these members effective on the first day of the following month after receiving notification from EOHHS. (e.g., if the Contractor is informed of a new member on December 15th, the Contractor shall enroll the member effective January 1st). Members must be mailed notification of enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from EOHHS of their enrollment.

The Contractor agrees to enroll, in the order in which he or she applies or is assigned, any eligible beneficiary who selects it or is assigned to it, regardless of the beneficiary's race, color, national origin, age, sex, sexual orientation, gender identity, ethnicity, language needs, disability, health status, or need for health services. The only exceptions will be if the member was previously disenrolled from the Health Plan as the result of a grievance filed by the Contractor, as described later in this section.

The Contractor agrees to have written policies and procedures for enrolling members, which specifically address the requirements for these members as set forth in this Agreement.

2.05.02.01 Enrollment of Newborns Up to 250% of FPL

The Contractor agrees to have written policies and procedures for enrolling the newborn children of RIte Care and Rhody Health Partners Expansion members effective to the time of birth to conform to Section 0348.75. 10 of the *Department of Human Services Manual.*

The Contractor will supply EOHHS with all necessary files in order to enroll newborns of the adult expansion population members. Contractor will adhere to the Managed Care Newborn File Discrepancy Policy and Procedure dated January 27, 2020.

Upon notification from the Contractor of a newborn, EOHHS will make a reasonable effort to:

- Enter each newborn into EOHHS's eligibility and MMIS systems, in a timely manner and
- Pay capitation retroactive to date of birth, in a timely manner.

2.05.02.02 Enrollment in Extended Family Planning

The Contractor agrees to offer an Extended Family Planning program (with premiums to be paid by EOHHS for women up to two hundred fifty percent (250%) FPL to persons who obtain Title XIX eligibility due to a pregnancy ("SOBRA-Extension" eligible) and who would lose eligibility sixty (60) days post-partum or sixty (60) days following birth or loss of the pregnancy. EOHHS will notify the Contractor of a member's change of eligibility to Extended Family Planning. The Contractor must have written policies and procedures for informing eligible members of this benefit.

2.05.02.03 Enrollment of Uninsured Children up to Age Eighteen Above 250 Percent of the FPL (Related Group)

The Contractor agrees to make coverage available to uninsured children under eighteen years of age with income above 250 percent of the Federal poverty level, at a monthly premium rate (payable by the family) not to exceed the full community rated non-group premium for the defined

benefit package, as described later in this chapter. The Contractor may not require evidence of insurability; however, it may restrict enrollment to:

- The open enrollment period; and
- Households that have not voluntarily dropped insurance coverage within the previous twelve (12) months, or voluntarily declined coverage through their employer within the previous twelve (12) months, and who sign a sworn affidavit to that effect .and provide supporting documentation as specified by EOHHS.

2.05.02.04 Enrollment under the Conversion Option (Related Group)

The Contractor agrees to offer a conversion option (payable by the member) to members who lose their eligibility. The Contractor will have written policies and procedures for enrolling all members covered under this Agreement, that are consistent with the procedures used for enrolling its commercial and employer-sponsored enrollees. The Contractor may restrict enrollment to all affected individuals within a family, if more than one person is losing eligibility including family members in a Related Group.

2.05.03 Change in Status

The Contractor agrees to report to EOHHS any changes in the status of individual members within five (5) calendar days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths or entry into a facility that would result in disenrollment and sources of third-party liability.

Contractor shall follow the EOHHS policy and procedures document titled, "EOHHS Medicaid Managed Care Organization (MCO) Requirements for Medicaid Member Demographic Changes." Contractor shall have a process for performing outreach calls and an approach for determining a member's most recent address and accurate address and telephone number.

The Contractor will ensure via its contracts that all subcontractors will report such changes in status to the Contractor.

2.05.04 Enrollment and Disenrollment Updates

EOHHS will provide the contractor with a daily update file of all members to be enrolled into RIte Care. The Contractor agrees to have written policies and procedures for receiving these updates and incorporating them into its management information system.

EOHHS will provide the Contractor with a monthly full roster of all members enrolled into Rhody Health Partners. This roster will be sent to the Contractor during the first financial cycle of each month, per a schedule supplied by EOHHS. The Contractor agrees to have written policies and procedures for receiving these updates and incorporating them into its management information

system.

2.05.05 Services for New Members

The Contractor agrees to make available the full scope of benefits to which a member is entitled immediately upon his or her enrollment.

2.05.06 New Member Orientation

The Contractor will have written policies and procedures for orienting new members to their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, how to utilize services in other circumstances, how to register a complaint or file an appeal and/or grievance and advance directives in accordance with 42 CFR 438.10[ii], 42 CFR 489.100[iii] and 42 CFR 489.102[iv] and Chapter 23-4.10 of the RI General Laws—HEALTH CARE POWER OF ATTORNEY and Chapter 23-4.11 of the RI General Laws—RIGHTS OF TERMINALLY ILL ACT. These policies and procedures will consider the multi-lingual, multi-cultural nature of the population. All enrollment notices, informational materials and instructional materials relating to members should be written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are blind or visually impaired, require oral interpretation and/or have limited reading proficiency. For members with limited English proficiency or whose primary language is not English and upon member request, written materials must be translated into the member's primary language. All enrollees must be informed that information is available in alternative formats and how to access those formats.

Orientation Process for members will include a contact to acquaint the member to the Contractor, to confirm, select or change the member's PCP, and to conduct or begin the process for the Health Risk Assessment and/or refer to care management as appropriate for the member's needs. Any script or other materials developed by the Contractor for this purpose is subject to the review and prior approval by EOHHS.

2.05.07 Assignment of Primary Care Providers (PCPs)

The Contractor will have written policies and procedures for assigning each of its members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

- If a Medicaid-only member does not select a PCP during enrollment, the Contractor will make an automatic assignment, taking into consideration such factors as current

provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. The Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. The Contractor will auto assign members to a NCQA recognized Patient Centered Medical Home, where possible.

- In addition to the above, EOHHS recognizes the importance of members being enrolled in a certified AE and a Patient Centered Medical Home (PCMH). EOHHS expects that, as applicable to the eligible populations, the Contractor will prioritize auto-assignment (a) first, to PCPs in a PCMH practice that is also a participating provider in a certified and contracted AE; second, to PCPs in a PCMH practice that are not in a contracted AE; third to non-PCMH PCP participating in a contracted AE; and fourth to PCPs in a non-PCMH and non- AE participating practice.

The Contractor is responsible for creating an auto-assignment algorithm and submitting this algorithm to EOHHS for review and approval within ninety (90) days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within sixty (60) days. The Contractor should consider the following when creating the algorithm: a) When auto assignment is being utilized, the Contractor must regularly monitor member panel size to ensure that providers have not exceeded their panel size; b) The provider's ability to comply with EOHHS's specified access standards, as well as the provider's ability to accommodate persons with disabilities or other special health needs must be considered during the auto-assignment process; c) In the event of a full panel or access issue, the algorithm for auto assignment must allow a provider to be skipped until the situation is resolved. Additionally, the Contractor will be required to provide registries of patients to each PCP facility where the patients are assigned, no less frequent then quarterly or at an interval defined by EOHHS.

- The Contractor will notify PCPs of newly assigned members in a timely manner.

- If a Medicaid-only member requests a change in his or her PCP, the Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day.

The Contractor will make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, the Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family member's PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.05.08 Changing PCPs

The Contractor will have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, the Contractor must allow members to select another PCP or make a re-assignment within ten (10) calendar days of the termination effective date.

2.05.09 Identification Cards

The State will issue a Medicaid identification card to members for their use when obtaining care for out-of-plan services.

The Contractor also agrees to issue an identification card for its members to use when obtaining Covered Services. The card may identify the holder as a RIte Care, Rhody Health Partners, or an ACA Adult Expansion Population member using an alpha or numeric indicator but should not be overtly different in design from the card issued to other enrolled groups.

The Contractor agrees to issue all Medicaid Managed Care members a permanent identification card within ten (10) calendar days after receiving notification from EOHHS of their enrollment. The card must include at least the following information:

- Health Plan name
- Twenty-four-hour Health Plan telephone number for use in urgent or emergent medical situations
- Telephone number for member Services function (if different)
- Telephone Number for Behavioral Health Services

2.05.10 Member Handbook and Initial New Member Materials

The Contractor agrees to use the State Developed Model Member Handbook and make it available to all new and existing members. An electronic copy of the Handbook is to be included on the Contractor's member website and available for viewing and downloading. Electronic copies of the handbook and initial new member material must be:

- In a format that is readily accessible;
- Located on the Contractor's website that is prominent and readily accessible;

- Provided in an electronic form which can be electronically retained and printed;
- Be consistent with content and language requirements; and
- The Contractor must notify the enrollee that the information is available in paper form without charge upon request; and the Contractor must provide, upon request, information in paper form within five (5) business days.

Additionally, members may request an alternate version (paper, audio or specific language) by contacting the Contractor's member services department.

The Contractor agrees to publish a new or revised member handbook within three (3) months of the effective date of this contract, and to update the handbook thereafter when there are material changes needed as determined by EOHHS. The Contractor will review all their member materials on an annual basis for any needed revisions.

Written material must use easily understood language and format. All written material must be written at no higher than a sixth-grade level. Written material must be available in alternative formats (audio, larger print, alternate languages) and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency or require materials in alternate languages. All enrollees must be informed that information is available in alternative formats and how to access those formats. Alternative media will not substitute for the above requirement to provide members with a written member handbook when requested. Contractors are required to provide newly enrolled members a "new member packet" when requested for those members with special needs an alternative format will be offered.

2.05.10.01 Required Information

The New member packet will be written at no higher than a sixth-grade level and contain at least the following:

- Information on how to obtain a member handbook and Provider Directory
- Information on how to obtain covered benefits, out of plan benefits and non-covered benefits
- Information on how to contact member services, including information on behavioral health and the hours of operation
- Information on Current Care and its benefits
- What to do in case of an emergency
- To the extent available, quality and performance indicators, including enrollee satisfaction

The member handbook will be written at no higher than a sixth-grade level and contain at least the following:

- Information on member services.
- Information on how to choose a PCP. Each member may choose his or her PCP to the extent possible and appropriate.
- Information on what to do when family size changes.
- Information on obtaining transportation
- Information on Interpreter and Translation Services
- Any restrictions on the member's freedom of choice among network providers.
- Information that enrollment Medicaid Managed Care does not restrict the choice of the provider from whom the member may receive family planning services and supplies.
- Information on member's right to change PCP.
- Information on amount, duration, and scope of Covered Services, including how to access Covered Services including behavioral health and long-term services and supports. This information must include sufficient detail to ensure that the member understands the benefits to which they are entitled.
- Procedures for obtaining benefits, including authorization requirements.
- Right to a second opinion.
- Members may obtain benefits, including family planning services, from out-of-network providers.
- The extent to which, and how, after-hours and emergency coverage are provided, including:
    - What constitutes an emergency medical condition, emergency services, and Post-Stabilization Care Services, with references to the definitions in 42 CFR 438.114(a)[v].
    - The fact that prior authorization is not required for Emergency Services.
    - The process and procedures for obtaining Emergency Services, including use of the 911-telephone system or its local equivalent.

- The locations of any Emergency Services and Post-Stabilization Care Services covered under the Agreement.

- The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.

- Information on the post-stabilization care services rules set forth in 42 CFR 422.113[vi].

- Policy on referrals for specialty care and other benefits not furnished by the member's Primary Care Provider.

- Information on Advance Directives as set forth in 42 C.F.R. §438.3(j)and 42 CFR 422.128[vii]. The Contractor agrees to reflect any changes in State law with regards to Advance directives in its written material within ninety (90) days of the effective date of the change as set forth in 42 C.F.R. §438.3(j)(4).

- Information on out-of-plan or out-of-network benefits

- Information on member's rights and responsibilities, including, in conformance with State and Federal law, the rights of mothers and newborns with respect to the duration of hospital stays.

- Information on member's rights and protections, as specified in 42 CFR 438.100[viii].

- Information on formal grievance, appeal and fair hearing procedures, and the information specified in 42 C.F.R. §438.3(g)(2)(xi)

- Information that a member may request disenrollment at any time from the Health Plan

- Information on cost-sharing responsibilities (if applicable; may be included as an insert)

- Information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement, including any cost sharing, and how transportation is provided.

- Information on member and provider fraud, waste and abuse

    - Provide examples of possible Medicaid fraud and abuse which might be undertaken by providers, vendors and enrollees

    - Inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free number established by the Contractor for reporting possible fraud and abuse

    - Instruct enrollees about how to contact EOHHS's Fraud Unit

- Information on grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400[ix] through 42 CFR 438.424[x], in a State-developed or State approved description that must include the following:
    - The member's right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing
    - The member's right to file grievances and appeals and their requirements and timeframes for filing
    - The availability of assistance in the filing process
    - The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone
    - The member's right to request continuation of Covered Benefits during an appeal or State Fair Hearing within the timeframes specified for filing; and the member may be liable for the cost of any continued benefits while the appeal is pending, if the final decision is adverse to the enrollee (as defined in 42 CFR 438.420[xi]).
    - Information on other resources to assist members
- Additional information that is available upon reasonable request, including the following:
    - Information on the structure and operation of the Contractor
    - Reports of transactions between the Contractor and parties of interest that are provided to the State, or other agencies. 1903(m)(4)(B).
    - Information on any physician incentive plans as set forth in 42 CFR 438.6[i]

Also, to be included are the following required by the RI General Laws Title 27 – Insurance Chapter 27-18.8 Rhode Island Health Care Accessibility and Quality Assurance Act (may be included as an insert):

- How does the Health Plan review and approve Covered Services?
- What if I refuse referral to a participating provider?
- Does the Health Plan require that I get a second opinion for any services?
- How does the Health Plan make sure that my personal health information is protected and kept confidential?
- How am I protected from discrimination?

- If I refuse treatment, will it affect my future treatment?
- How does the Health Plan pay providers?
- If I am covered by two or more Health Plans, what do I do?

The Contractor must have written policies regarding enrollee rights that cover:

- Each enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- Each enrollee is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Each enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- Each enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Each enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164[xii].

The Contractor must provide members, in adherence with 42 C.F.R. §438.3(g)(4)with written notice of any significant changes in enrollee rights or information at least thirty (30) days before the intended effective date of the change.

The Contractor will comply with requirements as specified in 42 CFR 438.10(i)(1) as follows:

(i) When appropriate Contractor must make available in electronic or paper form, the following information about its formulary:

(1) Which medications are covered (both generic and name brand).

What tier each medication is on.

Formulary drug lists must be made available on the Contractor's Web site in a machine readable file and format as specified by EOHHS.

2.05.10.02 Provider Directory/Network Listing

The Contractor agrees to develop a provider network listing and make it available to all new and existing members at all times. An electronic copy of the provider network listing is to be included on the Contractor's member website and available for viewing and downloading. Additionally,

members may request an alternate version (paper, audio or specific language) by contacting the Contractor's Member Services Department. Members receiving a hard copy of the network listing will be advised that the Contractor network may have changed since the directory was printed, and how to access current information regarding the Contractor's participating providers. The Contractor will update information included in their paper provider directory at least monthly and their electronic provider directory no later than thirty (30) calendar days after the Contractor received updated provider information.

Additionally, the Contractor will be responsible for maintaining updated provider information in an online searchable electronic provider directory. A PDF version of the hard copy of the network listing does not meet this requirement.

The provider listing will be written at no higher than a sixth-grade level and contain at least the following:

- Provider Name, address, telephone number
- Open panel status
- Provider's group/site affiliation
- Website URL
- Provider's cultural and linguistic capabilities, including languages (inclusive of American Sign Language), or a skilled medical interpreter at the provider's office and whether the provider has completed cultural competence training
- Office ability to accommodate members with physical disabilities, including the office, exam room(s) and equipment
- Specialties as appropriate
- Whether network providers will accept new members

The Contractor is asked to continue to work with the various entities involved with furthering the efforts designed to support the Triple Aim and Health System Transformation Program which includes partnership with the Rhode Island Quality Institute (RIQI) related to the development of a Statewide Common Provider Directory.

2.05.10.03 State Approval

The Contractor agrees to submit all member materials to EOHHS for approval prior to its use. This includes any changes made to language previously approved by EOHHS. The Contractor also agrees to make modifications in member materials if required by EOHHS. The Contractor understands that materials submitted for review and approval of revisions are subject to review and approval of entire content and not limited to revisions.

2.05.10.04 Languages Other Than English

The Contractor agrees to make available member handbooks in languages other than English consistent with interpreter service requirements and to distribute them to members requesting them, whether new or established members. The Contractor agrees to publish a revised member handbook within three (3) months of the effective date of this Agreement in all required languages, according to the non-English language enrollment profile of the Contractor on the effective date of this Agreement. The Contractor agrees to designate non-English language capability in its provider listings (including mental health and substance use providers) distributed to members.

2.05.11 Transitioning Members between Plans

It may be necessary to transition a member between Health Plans for a variety of reasons, including if the member changes Health Plans or if a change is ordered as part of a grievance resolution. The Contractor will have written policies and procedures for transferring relevant patient information in an efficient manner, including medical records and other pertinent materials, when transitioning a member to or from another Health Plan. The Contractor will transfer this information at no cost to the member. The Contractor will also transfer this information at no cost to the member in instances where the member had received Covered Services from a participating network provider who is no longer in the provider network and became a Non-Participating Provider. The Contractor may make a reasonable charge to a member who requests his or her own personal copy of a medical record, not to exceed limits established in the RI Department of Health Rules and Regulations for the Licensure and Discipline of Physician (R5-37-MD/DO).

The Contractor agrees to have in effect a transition of care policy to ensure continued access to services during a transition of a member to a new MCO when in the absence of continued services, the member would suffer serious detriment to either health or be at risk of hospitalization or institutionalization. Contractor agrees to provide care plan and associated documentation to new MCO in mutually agreed upon data fields and file format per EOHHS' discretion. This policy must include:

- Access to services consistent with the access the member previously had, and the member is permitted to retain their current provider for a period of one-hundred and eighty (180) days if that provider is not in the Contractor's network;
- Referrals to appropriate providers that are in the network;
- Fully and timely compliance with requests for historical utilization data from the new MCO in compliance with Federal and State law; and
- Any other necessary procedures as specified by EOHHS to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

2.05.12 Member Disenrollment

2.05.12.01 General Authority

EOHHS has sole authority to disenroll members from any of its contracted Medicaid Managed Care Health Plans, subject to the conditions described below. The Contractor is prohibited from processing a member's request to disenroll from the Health Plan. The Contractor will direct members to file the request to disenroll directly with EOHHS, or its delegate, for disenrollment determination.

2.05.12.02 Reasons for Disenrollment

EOHHS will disenroll members from a Health Plan for any of the following reasons:

- Loss of Medicaid eligibility or medically needy
- Loss of program eligibility
- Transfer to another Health Plan
- Death
- Relocation out-of-State
- Adjudicative actions
- Change of eligibility status
- Placement in a nursing facility for more than thirty (30) consecutive days, for Rhody Health Partners and Expansion members only
- Placement in Eleanor Slater, Tavares or an out-of- state hospital
- Eligibility determination error
- Just cause (as determined by EOHHS on an individual basis)
- The enrollees service needs (e.g. cesarean section and a tubal ligation) are not available within the network and that the enrollee's primary care provider or another provider determines that not receiving the services will subject the enrollee to unnecessary risk.

- Other reasons for disenrollment include but are not limited to, poor quality of care, lack of access to providers experienced in dealing with the enrollee's health needs.

A member has the right to disenroll with cause from the Contractor at any time. A member may disenroll from the plan either in writing or orally. A member may request disenrollment without cause during the ninety (90) days following the date of the recipient's initial enrollment with the Contractor. A member may request disenrollment without cause at least once every twelve (12) months thereafter. A member may request disenrollment under 42 CFR 438.56(d)(2), if the Contractor does not cover the service the member seeks, because of moral or religious grounds. Pursuant to 42 CFR 438.56(d)(2)(i), a member may request disenrollment, upon relocation out-of-state. A member may request disenrollment upon automatic reenrollment under 42 CFR 438.56(g)[xiii] if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity. A member may request disenrollment under 42 CFR 438.56(d)(2), if the member needs services to be performed at the same time and not all services are available within the network. The member's PCP or another provider must determine that receiving the services separately would subject the member to unnecessary risk. A member may request to disenroll without cause when EOHHS imposes, upon the Contractor, the intermediate sanctions identified in 42 CFR 438.702(a)(4)[xiv].

The Contractor cannot refuse to cover services because of moral or religious objections.

EOHHS reserves the right to disenroll members whom the Contractor is unable to contact within contractual timeframes or members for whom the Contractor cannot produce evidence of services provided within contractual timeframes, as set forth herein.

In accordance with 42 CFR 438.56(b)(2)[xv], the Contractor may not request disenrollment of a member because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the Health Plan seriously impairs the Health Plan's ability to furnish services to either the particular member or other members). The Contractor may request in writing that a member be disenrolled for the foregoing exception. All disenrollment's are subject to approval by EOHHS, and the Contractor will submit written disenrollment policies and procedures to EOHHS for approval.

2.05.12.03 Disenrollment Effective Dates

RIte Care member disenrollments, which occur outside of the open enrollment process, will become effective on the date specified by EOHHS, but not fewer than six (6) days after the Health Plan has been notified. Such disenrollment may be made effective sooner by mutual agreement of EOHHS and the Contractor. The Contractor agrees to have written policies and procedures for complying with State disenrollment orders.

Rhody Health Partner and ACA Adult Expansion population member disenrollment will occur monthly, and the Contractor will normally be notified at the first financial cycle (schedule

determined by EOHHS), for disenrollment effective at midnight the last day of the month in which the enrollment report was sent. Such disenrollment may be made effective sooner by mutual agreement of EOHHS and the Contractor. The Contractor agrees to have written policies and procedures for complying with State disenrollment orders. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member files the written request. If EOHHS fails to make a disenrollment determination within the described timeframe, the disenrollment is considered approved.

2.05.12.04 Disenrollment for Non-Payment of Premiums by RIte Care Group

RIte Care members, who obtain eligibility through criteria described in Section 2.04.01.01.3, Eligibility of Pregnant Women Under 250 Percent of the FPL ("SOBRA-Extension Group"), who are required to pay the premium-share and who fail to make premium payments for two (2) consecutive months, will be dropped from the program.

2.05.12.05 Disenrollment of Related Group

Individuals who qualify for coverage as part of a Related Group will be subject to the same premium collection and coverage termination provisions as other non-group (individual) subscribers to the Health Plan. The Contractor agrees to have written policies and procedures for premium collection and coverage termination and must make these known to members at time of enrollment.

2.05.12.06 Retrospective Enrollment and Retrospective Disenrollment

The Contractor is required in special circumstances to retrospectively enroll or retrospectively disenroll a member. The Contractor is required to ensure that the member is transitioned successfully and is required to work with EOHHS to reprocess any necessary claims.

2.05.12.07 Exemptions for Indians Served by an Indian Healthcare Provider

Indians Served by an Indian Health Care Provider. The Contractor will exempt Indians from payment of enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through CHS. The Contractor must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

2.06 IN-PLAN SERVICES

2.06.01 Description of Comprehensive Benefit Package

2.06.01.01 General

The Contractor must agree to make available the comprehensive benefit package to members covered under this Agreement and do so with a defined population health approach. A population health approach seeks to maintain and improve the health status of the entire population while systematically identifying those subpopulations with complex needs and implementing strategies to improve their health status and reduce health inequities among population groups. This includes the emphasis on transition to value-based payment arrangements with Accountable Entities, effective communication, meaningful analytic capacity and metrics, integrations of care across disciplines as appropriate, recognition of and strategies to address social determinants of health, care coordination, care management, and others. This should include approaches to such components as:

- Measuring population health status and outcomes, including sub-groups within the population
- Identifying baseline measures and targets for health improvement
- Identifying determinants of health outcomes and the identification of strategies for targeted interventions
- How such strategies integrate required components of this procurement and other Bidder developed initiatives combine to represent a comprehensive approach to population health

The comprehensive benefit package includes Medically Necessary inpatient and outpatient hospital services, physician/provider services, behavioral health services (a continuum of care including mental health and substance use services to individuals with SPMI and cognitive limitations), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, and preventive care.

The defining core values driving service delivery are:

- Population Health
- Consumer-focused services
- A holistic approach to health care and wellness
- Independence in the community
- Access to primary and specialty care when and where needed
- Respect and dignity of the individual

The guiding principles for service delivery are:

- Flexible options that match services with individual needs, both medical and social
- The establishment of a medical home that supports primary and preventive care
- A screening and assessment process that is coordinated and encompassing
- A focus on consumer self-management through education, community supports, and care coordination
- Maximum, creative, and effective use of existing infrastructure
- Methods for ensuring cost predictability
- Responsible stewardship of public dollars

The comprehensive benefit package does not include all services to which this group is entitled. EOHHS will continue to offer a schedule of out-of-plan benefits that the Contractor agrees to coordinate for their members. The Contractor is not responsible to deliver or reimburse for these services. Reimbursement for any out of plan benefits will be the responsibility of Fee for Service RI Medicaid.

ATTACHMENT A of this Agreement presents the full schedule of in-plan benefits contained in the comprehensive benefit package. The Contractor is authorized to offer alternatives to Medicaid State Plan services where services in an alternative setting would be more cost effective or efficient and is consistent with the best interests and wishes of the member.

ATTACHMENT B of this Attachment presents the schedule of out-of-plan benefits. The Contractor agrees to assist with the co-ordination of these services for those members who utilize them.

ATTACHMENT C of this Attachment presents a schedule of non-covered services.

The Contractor will provide thirty (30) days of nursing home services as medically and/or functionally necessary for the member, inclusive of skilled care, custodial care or any other level of nursing home care including but not limited to emergency placement, hospice and respite care. The Contractor will provide an array of Disease Management Programs and Self-Help Medical Management Programs. The Contractor will provide comprehensive treatment for gender dysphoria for all into the list of services included in the comprehensive benefit package.

2.06.01.02 Medical Services

The Contractor is required to comply with the requirements of ATTACHMENT A in-plan benefits for medically necessary services. These services will be provided by the Contractor as in-plan benefits.

2.06.01.03 Behavioral Health Services

ATTACHMENT O & ATTACHMENT P of this Agreement presents the continuum of care for children, adolescence and adult behavioral health services. These services will be provided by the Contractor as an in-plan benefit. The Contractor needs to comply with the requirements of ATTACHMENT O & ATTACHMENT P.

The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Quantitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-quantitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance.

The Contractor is required to ensure that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

2.06.01.04 Pharmacy Services

The Contractor agrees to comply with the requirements regarding covered pharmacy and over-the-counter (OTC) benefits. The Contractor will comply with the EOHHS Pharmacy Home Program and the Generics First Initiative, including the maintenance of the drug formulary in accordance with the direction of the EOHHS Pharmacy Committee.

2.06.01.05 Preventive Services

The Contractor may provide certain LTSS services in a limited fashion to members who do not currently meet the eligibility criteria for LTSS, to prevent admission, re-admission or reduce

lengths of stay in an institution. These Preventive Services are outlined in ATTACHMENT A.

2.06.01.06 Interpreter/Translation Services

During the enrollment process, EOHHS will seek to identify potential enrollees who speak a language other than English as their primary language. EOHHS will notify the Contractor when it knows of members who do not speak English as a primary language who have either selected or been assigned to the Health Plan.

If the Contractor has more than fifty (50) members who speak a single language other than English as a primary language, the Contractor agrees to make available general written materials, such as its member handbook, in that language. The Contractor agrees to be responsible for a true translation of materials prior-approved in English by EOHHS, subject to State oversight. The Contractor will forward all translated materials to applicable members.

The Contractor agrees to make available interpreter services. Interpreter services will be made available as practical and necessary by telephone, and/or in-person to ensure that members are able to communicate with the Contractor and its providers and receive all covered benefits in a timely manner. Members will have the option of in-person interpreter services, if planned sufficiently in advance according to the Contractor policies and procedures, in conformance with Title VI of the Civil Rights Act.

In addition, the Contractor agrees to conform with standards outlined in the Americans with Disabilities Act (ADA) for purposes of communicating with, including about out-of-plan services, and providing accessible services to its visually and hearing impaired, and physically disabled members.

2.06.01.07 Telehealth

The Contractor is required to identify policies and procedures which describe the organization, policies and procedures surrounding a Telehealth program. A Telehealth program should include but not be limited to the following covered services: monitoring of patient vital signs; patient education; medication management; equipment management; review of patient trends and/or other changes in patient condition necessitating professional intervention; and other activities deemed necessary and appropriate according to a member's plan of care.

Contractor must comply with HB No. 6032 SUB A as amended AN ACT RELATING TO INSURANCE -- THE TELEMEDICINE COVERAGE ACT (Amends the provisions of the telemedicine coverage act and provide coverage for telemedicine under Rhode Island Medicaid.) and SB No. 4 SUB B as amended AN ACT RELATING TO INSURANCE -- THE TELEMEDICINE COVERAGE ACT (Amends the provisions of the telemedicine coverage act and provide coverage for telemedicine under Rhode Island Medicaid).

2.06.01.08 EPSDT

The Contractor agrees to work with contracted providers to provide the full early and periodic screening, diagnosis, and treatment services to all eligible children, pregnant women, unborn children, and young adults up to age 21 in accordance with the *Rhode Island* EPSDT Periodicity Schedule, that assures that all EPSDT billable services are coded with established CPT/HCPC codes and submitted through the normal administrative claims processes as included in ATTACHMENT ED or modified by EOHHS during the period of this Agreement.

In addition, the Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with Rhode Island EPSDT Periodicity Schedule. These policies and procedures will emphasize outreach and compliance monitoring for children and adolescents (young adults), considering the multi-lingual, multi-cultural nature of the population as well as other unique characteristics of this population.

The full scope of the Contractor's EPSDT requirements is described below.

Screening

The Health Plan must work with contracted providers to conduct interperiodic EPSDT screens on RIte Care and all ACA Adult Expansion Population members under age 21 (i.e. 19 and 20-year old under this Agreement) to identify health and developmental problems in conformance with ATTACHMENT ED to this Agreement. Additional screens should be provided as Medically Necessary. At a minimum, these screens must include:

- A comprehensive health and developmental history, including health education, nutrition assessment, immunization history, and developmental assessment
- Immunizations according to the Rhode Island EPSDT Periodicity Schedule
- An unclothed physical examination
- Laboratory tests including lead, TB, and newborn screenings as medically indicated
- Vision testing
- Hearing testing
- Dental screening oral examination by PCP as part of a comprehensive examination required before age one (1)
- All other medically indicated screening services
- And provide EOHHS with a list of established CPT/HCPC codes used to identify all billable services included in the EPSDT schedule.

Diagnosis and Treatment

If a suspected problem is detected by a screening examination as described above, the member will be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem discovered during an EPSDT screen. Such Medically Necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-covered services as defined in the Social Security Act.

The Contractor will assure that all Medically Necessary, Medicaid-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medicaid Plan nor included in the comprehensive benefit package, the Contractor may bill Medicaid fee-for-service for these services if provided by the Contractor. Such services are outlined in ATTACHMENT B of this Agreement.

Tracking

The Contractor will establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- Initial visit for newborns. The initial EPSDT screen will be the newborn physical examination in the hospital.
- Preventive pediatric visits in accordance with the Rhode Island EPSDT Periodicity Schedule.
- Semi-annual preventive dental visits beginning at age one (1) in accordance with the Rhode Island EPSDT Periodicity Schedule.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

Follow-up and Outreach

The Contractor will have an established process for reminders, follow-ups, and outreach to members that includes:

- Written notification of upcoming or missed key points of contact within a set time period, taking into consideration language and literacy capabilities of members.
- Telephone protocols to remind members of upcoming visits and follow-up on missed appointments within a set time period.

- Protocols for conducting outreach with non-compliant members, including home visits, as appropriate, and addressing access barriers such as arranging transportation, interpreters, connections with multi-lingual/multi-cultural service providers, etc.

This process must take into account the multi-lingual, multi-cultural nature of the population as well as other unique characteristics of this population such as a greater frequency of changes of address and absence of telephones.

2.06.01.09 Enhanced Services

One of the goals of EOHHS is to reduce barriers to care that exist in the fee-for-service delivery system. To accomplish this goal, the Contractor agrees to offer a schedule of enhanced services, as described below.

General Tracking, Follow-up and Outreach

EOHHS places a strong emphasis on primary and preventive care. In order to assure that members comply with initial and preventive visit schedules, and with preventive screening recommendations, the Contractor agrees to have written policies and procedures to conduct general tracking, follow-up and outreach in addition to what is undertaken as part of the EPSDT program. Specifically, the Contractor agrees to:

- Educate members about how to access services including the role of the PCP, prior authorization requirements, and after-hours access requirements.

- Educate members about preventive visit and screening recommendations, including an initial visit to the PCP for all new enrollees.

- Establish tracking systems to measure member compliance with preventive service recommendations and with referral recommendations that result from preventive visits.

- Remind members about upcoming preventive visits/screens and conduct vigorous follow-up and outreach with members who miss visits, using mail, telephone, and home outreach methods as appropriate.

- Remind members about upcoming appointments and conduct vigorous follow-up and outreach with members who miss visits, using mail, telephone, and home outreach methods as appropriate.

- Identify and resolve member barriers to preventive care (such as language or transportation).

- Work with contracted providers to assure compliance with EPSDT screening including: 1) Providers are identifying and submitting through the normal

administrative claims processes and using the appropriate CPT/HCPC codes to track EPSDT services, 2) the fee schedule used to reimburse for services, and 3) assurance that the fee schedule is sufficient to incentivize providers to offer and submit the service in their normal billing cycle.

These policies and procedures will take into account the unique characteristics of the members covered under this Agreement.

Prenatal Tracking, Follow-up and Outreach

The Contractor agrees to have written policies and procedures for educating enrollees about the importance of early prenatal care and is encouraged to offer incentives to women who seek prenatal care during their first trimester of pregnancy and who complete the requisite number of prenatal visits. In addition, the Contractor agrees to do the following:

- Perform appropriate clinical and social risk assessment of pregnant women.
- Make available the opportunity for pregnant women to meet with the child's primary care provider (if known) prior to delivery.
- Schedule or assure that its PCPs or prenatal care providers schedule a post-partum visit no more than six (6) weeks after delivery.
- Ensure that family planning counseling is provided and, if appropriate, the Extended Family Planning benefit explained during the last trimester of pregnancy and at the six-week post-partum visit.

As with EPSDT follow-up and outreach, these policies and procedures will take into account the unique characteristics of members.

Tobacco Cessation

The Contractor agrees to have written policies and procedures to assess members for smoking behavior, particularly adolescents, pregnant women, and persons with chronic medical conditions. The Contractor will arrange for tobacco cessation programs and services to be offered to all members at convenient times and in accessible locations and will cover tobacco cessation supplies specified in ATTACHMENT A.

Nutrition Services

The Contractor agrees to incorporate comprehensive nutrition assessments, education, and counseling into preventive medical care, including prenatal and preventive pediatric visits. Referrals will be made to a licensed dietitian for therapeutic nutrition counseling for certain conditions in accordance with EOHHS Nutrition Standards for members. The nutrition standards are included as ATTACHMENT E of this Agreement.

Transportation

EOHHS contracts with a non-emergency transportation broker for all members. Through this service, for medically necessary or behavioral health appointments members are offered bus passes and, when necessary, transport on other types of non-emergency medical vehicles (chair vans, ambulances, etc.). For its part, the Contractor agrees to coordinate the arrangement of transportation for its members through the Broker when a means of transport other than by bus is required.

The Contractor is required to provide emergency transportation for members when medically necessary, including Out-of-State, as part of their prepaid benefit.

2.06.01.10 In Lieu of Services

The Contractor may offer cost effective alternative services/equipment to members, where the services/equipment are not identified as an in-plan benefit, when EOHHS has determined that the use of such alternative services/equipment are medically appropriate and cost effective. The Contractor may not require the member to accept an in lieu of service in the place of a covered service. The Contractor has flexibility and may provide all the in lieu of services identified in ATTACHMENT A. If the Contractor seeks to provide an in lieu of service that is not listed in ATTACHMENT A, the Contractor must receive prior authorization from EOHHS to deliver the proposed service as defined in *EOHHS MCO Core Contract Requirements for Requesting In Lieu of Services.*

The Contractor must follow the procedures below for obtaining prior approval for in lieu of services not identified in ATTACHMENT A.

- Requests for prior authorization must be submitted by the Contractor only;
- Requests for prior authorization must be submitted through completion of the "Request for Cost-Effective Alternative (CEA)" form along with any accompanying documentation;
- Submission must be sent by secure email to the designated EOHHS employee; and
- To ensure EOHHS has the opportunity to adequately consider all requests for in lieu of services, the Contractor should submit the request at least 30 days prior to the desired date of service.

In addition to the services identified in ATTACHMENT A as in lieu of services, another example of an approved in lieu of service is:

- Psychiatric or substance use disorder treatment services provided in an Institution for Mental Disease (IMD) for members between the ages of 21-64, subject to the limitations described in 42 C.F.R. § 438.6(e).

2.06.01.11 Coverage of Complementary Alternative Medicine Services (CAM)

The Contractor will offer members Complementary Alternative Medicine Services (CAM) defined as treatment from a chiropractor, acupuncturist, and/or massage therapist. Use of CAM services must be determined by the Contractor to be medically necessary to manage a member's chronic pain. The Contractor will provide members with CAM services based on medical necessity criteria. The Contractor will evaluate a Member's continued need for CAM services on an ongoing basis but no less than annually.

The Contractor will establish and maintain a geographic network designed to accomplish the following goals: (1) maintain CAM providers in sufficient numbers, varieties, and geographic areas; and (2) make available all CAM services in a timely manner.

The Contractor will ensure that all network providers are credentialed in a manner consistent with the National Committee for Quality Assurance (NCQA), as well as any State and/or Federal regulations.

The Contractor will develop policies and procedures to determine the following:

- Criteria for member access, based on medical necessity, to CAM services;
- Criteria defining active member engagement for the continuation of CAM services;
- Components of the person-centered plan of care, including the development and review process;
- Strategies for communicating and outreaching to members and CAM providers;
- Process for obtaining member input; and
- Process for communicating with members' non-CAM providers.

EOHHS reserves the right to review all the Contractor's criteria, processes, strategies, and procedures prior to implementation and as requested.

The Contractor agrees to provide EOHHS with quarterly operational, programmatic and financial reports, and additional ad hoc data in a manner acceptable to EOHHS. The format of the reports will be mutually agreed upon by the parties and approved by EOHHS.

The Contractor will develop a performance evaluation to measure outcomes of CAM services for members. The evaluation will include:

- Data on CAM service providers.
- Data on members receiving CAM services.

- Pain reduction/pain management success rates.
- Lessons learned and recommendations for improvement/modifications.

The Contractor will perform the evaluation annually and submit the performance evaluation criteria and results to EOHHS following a six (6) month run out period.

2.06.01.12 Health Homes for Children, Also Referred to as Cedar Health Homes (CHH)

Contractor will provide family-centered, intensive care management and coordination services to children, including:

- comprehensive care management;
- care coordination;
- referral to community and social support services (formal and informal);
- individual and family support services;
- comprehensive transitional care; and
- health promotion

Contractor will deliver Health Home services to children, within the following parameters:

- The services must focus on providing enhanced guidance and psychoeducation to promote health and wellness by helping families understand their child's clinical needs, health conditions, medical needs, and/or risk and protective factors.
- The care coordination must include in-home, hands-on support and coaching that build a family's skills to successfully navigate systems of care and advocate for their child(ren) and family to ensure access and participation in services that meet the child and/or family needs.
- Services must be delivered by providers who have experience in delivering health homes in a family's place of residence/community and are trusted members of the communities in which the member resides.

2.06.02 Enrollee/Provider Communication

The Contractor may not prohibit, or otherwise restrict, a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of a member about: (1) the member's health status, medical care, or treatment options including any alternative treatment that may be self-administered; (2) any information the member needs in order to decide among all relevant treatment options; (3) the risks, benefits, and consequences of treatment or non-treatment; or (4) the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

The Contractor, which would otherwise be required to provide, reimburse for, or provide coverage

of, a counseling or referral service because of the requirement in the paragraph above, is not required to do so if the Contractor objects on moral or religious grounds. If the Contractor elects this option, the Contractor agrees to furnish information about the services it does not cover as follows:

- To EOHHS, upon execution of this Agreement or whenever the Contractor adopts the policy during the term of this Agreement.
- To potential members, before and during enrollment.
- To members, within thirty (30) days after adopting the policy with respect to any particular service.

EOHHS reserves the right to adjust the Contractor's rates in ATTACHMENT J as a consequence of the Contractor's policy.

2.06.03 Second Opinion

A member is entitled to a second opinion from a qualified health professional within the network or, if a network provider is not available to provide a second opinion, the Contractor must arrange for a second opinion by a non-participating provider outside of the network. Except for allowed cost-sharing, the member is not responsible for the cost of obtaining a second opinion.

2.06.04 New In-Plan Services and In-Plan Service Coverage Arrangements

EOHHS reserves the right to add new in-plan services or to move certain services out of plan (e.g. pharmacy) at any time. EOHHS's intent to add any new in-plan service and the terms upon which any new in-plan service would be covered under this Agreement or to move certain services out of plan (e.g. pharmacy) will be made according to the notice provisions in Section 3.01.09 of this Agreement. The Contractor will have forty-five (45) days from the date of receipt of such notice to either accept or reject in writing the addition of the new in-plan service and the terms proposed. Acceptance will be formalized through an amendment to this Agreement, as provided in ARTICLE III: CONTRACT TERMS AND CONDITIONS of the Agreement.

EOHHS further reserves the right to modify coverage arrangements for in-plan services. (e.g., establishing co-payments for pharmacy services). Any such changes will be made according to the notice provisions in Section 3.01.09 of the Agreement and will be accompanied by actuarially sound adjustment to the capitation rates in ATTACHMENT J of this Agreement. This will be formalized through an amendment to this Agreement as provided in ARTICLE III: CONTRACT TERMS AND CONDITIONS of the Agreement.

2.06.05 Care Management and Care Coordination

2.06.05.01 Coordination of Care

The Contractor will ensure coordination of care of all covered benefits under this Agreement including those provided for children, adolescents and adults for RIte Care, Rhody Health Partners and the Affordable Care Act Adult Expansion Populations. Coordination of care includes identification and follow-up of members with significant health and social needs that are at high risk of poor health outcomes, ensuring coordination of services and appropriate referral and follow-up. In particular, the Contractor will ensure coordination between medical services and behavioral health services required by the members.

The Contractor will provide a care coordination program designed to help members who may or may not have a chronic disease, but have acute physical health, behavioral health, or social needs that impact health status and/or are at risk of further exacerbation of their illness. When the members need warrants immediate attention, care coordination will ensure access to primary care and behavioral health services. The goal of care coordination is to reduce the impact of any adverse outcome. Care coordination services are short term and time limited and should not be confused with intensive care management and/or other interventions. Services may include assistance with making or keeping needed medical or behavioral health appointments, hospital discharge planning, health coaching, and referrals related to the member's immediate needs. Members are identified for care coordination because their needs do not meet the level of intensive care management as defined in this contract. The Contractor will develop guidelines for care coordination that will be submitted to EOHHS for review and approval. The Contract will have approval from the EOHHS for any subsequent changes prior to implementation of said changes. The Contractor will demonstrate the link to other Contractor systems such as quality, member services, utilization review, and appeals and grievances.

For member who are identified as having special health care needs, the Contractor will:

- Approve care plans in a timely manner if the Contractor's approval is required.
- Ensure that care plans are developed in accordance with applicable state quality assurance and utilization review standards.
- Ensure that care plans are reviewed upon reassessment of functional need, at least every twelve (12) months, or when the member's circumstances or needs change significantly, or at the request of the member.

As a community-based program supported by EOHHS, the Contractor is required to coordinate, participate, and collaborate with EOHHS in the enhancement and improvement of Community Health Teams. The Contractor is required to provide updates and reports on this program as requested by EOHHS.

2.06.05.02 Children with Special Health Care Needs

The coordination of care is of the utmost importance for Children with Special Health Care Needs.

The Contractor will treat Children with Special Health Care Needs as a high-risk population.

The Contractor is required to be in compliance with all DCYF policies regarding the care and treatment of youth in substitute care. The Contractor is required to meet with DCYF and EOHHS at a time interval specified by EOHHS and is required to provide timely ad-hoc reports when requested.

2.06.05.03 Continuity of Care for Former Qualified Health Plan Members

For a transitional period of at least ninety (90) days following an Enrollee's effective date of enrollment with the Contractor, when that member can demonstrate that he or she was covered by a Qualified Health Plan (the "member's QHP") for at least one day during the ninety (90) days preceding enrollment with the Contractor, the Contractor must take the following steps to ensure continuity of that member's care:

- The Contractor must accept any prior authorizations authorized by the member's QHP and for which the provider shows evidence of the prior authorization and which would still be in effect if the member were still covered by the member's QHP.
- The Contractor must allow Enrollee to see an out-of-network provider on an in-network basis if (1) that provider was a part of the member's QHP network, and (2) the member had been in the care of that provider for a period of at least six months. Whether or not such provider agrees to accept the Contractor's in-network rates, the balance-billing of the Medicaid beneficiary is prohibited.
- The Contractor must make a formulary exception to allow the member to refill or renew any prescription which the member had received through the member's QHP as part of its formulary and which is not on the Contractor's formulary.
- To the extent allowable by HIPAA and other law, the Contractor must coordinate with the member's QHP to ensure a smooth transition of medical management responsibilities and must abide by further continuity of care policies which may be adopted by EOHHS.

2.06.05.04 Care Management Program

The Contractor is responsible for ensuring by the contract start date that an EOHHS approved care management strategy and plan is in place, which addresses the preventive and chronic healthcare needs of its members, inclusive of behavioral health social services and supports and other social determinants that impact member health outcomes. The care management strategy and plan for members with significant health and social needs that are at high risk of poor health outcomes, including, but not limited to, adults with complex health needs, Children with Special Health Care Needs, other children with potentially care management service's needs, individuals receiving home and community-based services or children with high need, HIV/AIDS, mental illness,

addiction issues or those recently discharged from correctional facilities. The care management plan will describe the care management program including but not limited to the policies, procedures, practices and criteria for conducting the Health Risk Assessment and conducting providing care coordination and Intensive Care Management Services that comply with the requirements contained in ATTACHMENT G. The Care Management strategy and plan is subject to the approval of EOHHS. The Contractor will submit the Care Management strategy and plan to EOHHS thirty (30) days prior to the contract commencement date.

The Contractor will implement processes to assess, monitor and evaluate the services to all care management subpopulations described in the care management strategy and plan, including but not limited to, defining any of the ongoing special conditions for focus of the care management program that requires a course of treatment, the frequency of ongoing care monitoring, and the number of members and their projected Medicaid eligibility category, type of disability, chronic condition, race, ethnicity, gender and age.

In reference to HIV case management, for all Medicaid members, HIV positive; HIV negative; HIV medical; and HIV non-medical case management services will be considered an in-plan benefit. The Contractor will ensure that it has a robust provider network to meet the needs of the community. The Contractor will provide reporting on these services to EOHHS, at a frequency determined by EOHHS. The Contractor will ensure that all of its contracted providers for this service as in compliance with EOHHS's HIV Targeted Care/Case Management (TCM) Provider Manual and accompanying HIV TCM Toolbox. The Contractor will also be responsible for monitoring and reporting on quality metrics in reference to these programs. The Contractor will submit evidence of compliance to this requirement.

The Contractor will designate a Program Coordinator (and/or Care Manager). The Program Coordinator/Care Manager will be a licensed professional who will assure that the Health Risk Assessment and appropriate care management activities are completed for each member; for performance of this role the Program Coordinator/Care Manager must be currently licensed by the State as one of the following: licensed independent clinical social worker, bachelor's or master's prepared registered nurse, or psychologist. The responsibilities of the Program Coordinator/Care Manager as outlined will be inclusive of behavioral health services; the Care Manager will assure that behavioral health services are provided in compliance with EOHHS Care Management protocols and in active coordination with other services provided by the Contractor.

The Program Coordinator/Care Manager will ensure that the component elements of care management are completed on a timely basis. The Health Risk Assessment must be completed within ninety (90) days of the member's enrollment with the Contractor. In such event where the Contractor is unable to complete the Health Risk Assessment on a timely basis, the Contractor must be able to provide documented evidence that it made a bona fide effort to conduct the Health Risk Assessment. In the initial start-up period, the Health Plan has one-hundred and eighty (180) days to conduct the Health Risk Assessment of members who become eligible at the beginning of the contract.

The Contractor will maintain records to identify care coordination and Intensive Care Management activities. For all members receiving intensive care management, records will include the resulting

Intensive Care Management Plan or documentation of why such a plan is not needed.

In accordance with 42 CFR 438.208(c)(3), care management plans are to be evaluated and updated as needed while active, but no less frequently than every twelve (12) months or when the member's circumstances or needs change significantly, or at the request of the member.

For members with special health care needs, the Contractor will:

- Approve care plans in a timely manner, if the approval is required by the Contractor; and
- Develop care plans in accordance with state quality assurance and utilization review standards.

Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island. Rhode Island staff will be key for their ability to work closely with local resources. Face-to-face meetings will be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs, social supports and services and out-of-plan services. The Program Coordinator (and/or Care Manager) and all their needed support staff will be located in Rhode Island.

EOHHS considers interactive communications between Primary Care Providers, behavioral health providers and other Specialists to be an important program objective to ensure that members receive the right care in the right setting. The Contractor is encouraged to promote interactive communication methods or systems that enable timely exchange of member information between collaborating providers.

The Contractor will have a care management system that employs and/or collaborates with community and provider-based care coordinators and care managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a member. Members needing care coordination or care management will be identified through the health risk assessment, evaluation of claims data, provider referral or other mechanisms as appropriate. The Contractor will inform members how to contact their case manager.

2.06.05.06 Recovery Navigation Program (RNP)

The Contractor is required to coordinate and collaborate with the RNP Program. Coordination will include assistance with discharge planning to appropriate detox in-patient or outpatient services as they relate to substance use and behavioral health treatments.

2.07 COORDINATION WITH OUT-OF-PLAN SERVICES AND OTHER HEALTH/ SOCIAL SERVICES AVAILABLE TO MEMBERS

2.07.01 General

EOHHS supports various special service programs targeted to persons who may be covered by RIte Care, ACA Expansion or Rhody Health Partners. The Contractor is not obligated to provide or pay for any non-plan, non-capitated services. However, the Contractor will develop policies and procedures to guide coordination of its in-plan and other service delivery with services delivered outside of the Health Plan. Examples of services with which it must coordinate are described below, but this list is not exhaustive.

Although such services are not Health Plan covered benefits, EOHHS expects that the Contractor will promote and coordinate such services to avoid service fragmentation. In addition, these services are significant for the promotion of the health of RIte Care, ACA Expansion and Rhody Health Partners members and families and to assure optimum outcome of the clinical services.

2.07.02 Non-Emergency Transportation

The Contractor will coordinate and collaborate with the EOHHS-selected transportation broker to assist members in accessing non-emergency transportation. Requirements will include but will not be limited to supplying provider directories to the broker on a annually basis and complying with all EOHHS-established referral policies.

2.07.03 Special Education

The Contractor will not be financially liable for speech, hearing, and language therapy services or other Medicaid-covered services specified in Special Education Individual Education Plans (IEPs) and provided to special education students, but it will have written policies and procedures for promptly transferring medical and developmental data and for coordinating ongoing care with special education services. Included within these policies and procedures will be provisions for the Contractor participation in IEP development and monitoring, if so requested.

2.07.04 Department of Behavioral Health, Developmental Disabilities and Hospitals

The Contractor is required to assist members accessing necessary developmental disabilities services that are provided by the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) as out-of-plan services as specified in ATTACHMENT B.

2.07.05 Rhode Island Department of Human Services

The Contractor agrees to assist members in accessing necessary services provided by the RI Department of Human Services (DHS). These services include but are not limited to, services of the Office of Rehabilitation Services, and the State Nutrition Assistance Program (SNAP).

2.07.06 Rhode Island Department of Health

The Contractor agrees to assist members in accessing necessary services provided by the RI Department of Health (DOH). These services include but are not limited to the Office of Special Health Care Needs, the Chronic Conditions Workforce Initiative, and the Chronic Disease Self-Management Programs.

The State operates a WIC Nutrition program through the Department of Health for pregnant, postpartum and breast-feeding women and children, birth to age five who are at risk for nutritionally related health and developmental conditions. For its part, the Contractor will have written policies and procedures for referring pregnant women and children to the WIC program.

The Family Outreach Program is a family support and developmental screening program for families of infants identified at birth with physical or social developmental risk factors. It is not medical or therapeutic in nature. Community based home visitors help link families with resources in their own community that will help parents provide a safe and nurturing environment for a developing child. They also provide developmental screening for referral to EPSDT.

The Department of Health provides a variety of services within its Lead Program, including case management, home assessments, environmental interventions, and consultation to providers. The State has created Lead Centers to provide comprehensive case management for children with lead poisoning and their families, education and certain lead abatement services, as necessary. The Contractor agrees to have written policies and a procedure to provide lead screening, education, and any Medically Necessary lead reduction therapies and agrees to work cooperatively with the Department of Health Lead Program or the Lead Centers to coordinate delivery of these services with those provided through the Contractor.

2.07.06.01 Department of Children, Youth and Families/Department of Health/ Rhode Island Executive Office of Health and Human Services Special Programs

The Rhode Island Department of Health, Rhode Island Department of Children, Youth, and Families ("DCYF"), and EOHHS operate a number of social and public health programs that are available to RIte Care members. Several key programs are described below, along with the Health Plan's accompanying coordination responsibilities. Health Plans are expected to coordinate with/refer members to other programs offered by the State, such as Comprehensive Emergency Services Program (DCYF), and the Early Start Program.

2.07.06.02 Adolescent Self-Sufficiency Collaborative

Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. The ASSC provides: (1) case management services, including home visiting, and intensive case management to minor parents

focusing on parenting education and life-skills development; (2) pregnancy prevention programs that involve teen parents, their parents and other family members, including "hard-to-serve" families where English is not the primary language; and (3) access to programs where participants learn and practice pre-employment/work maturity skills, where they explore vocational options and where they participate in community work experience settings matching their skills and interests. The Contractor is encouraged to make referrals to the ASSC programs as appropriate.

2.07.07 Care Transformation Collaborative of Rhode Island

The Contractor is required to participate both financially and operationally in the Care Transformation Collaborative of Rhode Island (CTC-RI), including Patient-Centered Medical Home for Kids (PCMH-Kids), according to the requirements for participation as set forth by EOHHS and consistent with parameters established by the CTC-RI Executive Committee. This participation will include, but not be limited to provision of high utilizer reports to participating practice sites, provider PMPM payments, CTC-RI administrative payments, and referrals to community health teams. Reporting requirements for all providers shall follow OHIC procedures which can be found at the following link; http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php

2.07.08 Level IV Alcohol and Drug Detoxification Program

For all members who are admitted to Level IV alcohol and drug detoxification programs, the Contractor is required to pay the negotiated per member per month rate, as documented in ATTACHMENT L, for Level IV alcohol and drug detoxification programs' case management.

2.07.09 CurrentCare

CurrentCare, Rhode Island's Health Information Exchange is a secure and private electronic health network that stores and shares a patient's medical information when a participating medical provider needs access to treat a patient. Enrolling in CurrentCare keeps providers informed, allowing them to coordinate member's health care easily. The Contractor will support CurrentCare by providing information and education to members on the benefits of enrolling in CurrentCare.

The Contractor will include language in all provider contracts to encourage provider enrollment as a user of CurrentCare, including hospital alerts. The Contractor will cooperate with the state-designated Regional Health Information Organization in engaging provider participation in Direct Messaging services to improve care coordination. The Contractor will include language that requires providers to encourage and assist their high utilizing patients to enroll in CurrentCare. The term "High utilizers" will be defined by the Contractor and approved by EOHHS. The Contractor will include this language in all primary care and specialty provider contracts as they become eligible for renewal.

2.07.10 Dental Services

The Contractor agrees to assist a member in obtaining dental services when so requested by a member. The Contractor is required to provide information on the RIte Smiles program and member marketing materials. The Contractor will collaborate with the RIte Smiles program to coordinate and promote access to dental services for children and young adults.

2.07.11 All Payer Claims Database

The Rhode Island All Payer Claims Database (RI-APCD), is a repository of healthcare insurance payment information for people living in Rhode Island. The data will come from the major health insurance companies doing business in Rhode Island, including fully-insured and self-funded commercial plans, Medicare and Medicaid. The development of Rhode Island All Payer Claims Database is a collaborative effort amongst the Rhode Island Department of Health, the Office of the Health Insurance Commissioner, the Health Benefits Exchanges, and EOHHS. Pursuant to RI General Law Section 23-17.17-10, the Contractor will submit timely data exchange files to the All Payer Claims Database (APCD), according to the schedule that is established by the RI-APCD.

2.08 PROVIDER NETWORKS

2.08.01 Network Composition

The Contractor will establish and maintain a robust geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder and long-term services and supports (including nursing homes and home and community-based care) services for the anticipated number of enrollees in the services area; (2) maintain providers in sufficient number, mix, and geographic areas; and (3) make available all services in a timely manner. Pursuant to 42 CFR 438.206(c)(3), the Contractor will ensure that its contracted providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

The Contractor agrees to maintain and monitor a network of appropriate providers that is supported by written agreements and can sufficiently demonstrate to EOHHS' satisfaction the Contractor's ability to provide Covered Services under this Agreement. The Contractor will maintain a Network Development Plan to address continuous recruitment and retention of new providers, plans for ongoing network development, and plans to create goal targets for specific numbers of providers in networks. Members must have access to services that are at least equal to, or better than community norms. Members will be allowed to choose their network provider to the extent possible and appropriate. In establishing and maintaining the network, the Contractor will consider the following:

- Anticipated enrollment for the members covered under this Agreement

- A sufficient number of PCPs who will accept new members within the service area to ensure the Contractor can meet the access standards required.
- Ability to provide all Medicaid managed care children a full continuum of behavioral health and substance use disorder services. The Contractor's services will address all levels of need.
- Ability to provide all Medicaid managed care adults a full continuum of behavioral health and substance use services. The Contractor's services will address all levels of need. The Contractor will have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community-based providers.
- Expected utilization of services taking into consideration the characteristics and health care needs of members for which the Contractor is, or will be, responsible
- Numbers and types (in terms of training, experience, and specialization) of providers, specifically specialty providers, required to furnish the services contracted for herein
- Numbers of providers who are not accepting new Medicaid patients
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.
- "Cultural Competency" of providers and office staff. "Cultural Competency" is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.
- "Disability Competency" of providers and the physical accessibility of their offices. "Disability Competency" is defined as the capacity of health professionals and health educators to support the health and wellness of people with disabilities through their disability knowledge, experience and expertise.
- Ability of network providers to communicate with limited English proficient enrollees in their preferred language.
- Availability of triage lines or screening systems as well as the use of telemedicine, E-visits and/or other evolving and innovative technological solutions.

The Contractor will develop and maintain its network to maximize the availability of primary and specialty care access to reduce utilization of emergency services, preventable hospital admission/re-admissions, and the use of avoidable costly medical procedures.

The Contractor agrees that if the network is unable to provide necessary services, covered under this Agreement, to a particular member, the Contractor must adequately and on a timely basis cover these services out of network, for as long as the Contractor is unable to provide them. The Contractor will coordinate with the out-of-network provider to arrange payment and ensure that the member is held harmless. The Contractor will report out of network utilization by provider type as part of the monthly access reporting to EOHHS.

The Contractor agrees to ensure that all in-plan services covered under the Medicaid State Plan and provided for in ATTACHMENT A are available and accessible to members, according to 42 CFR 438.206[xvi].

The Contractor agrees to ensure that providers will meet EOHHS standards for timely access to care and services, taking into account the urgency of need for services.

The Contractor agrees to ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only members.

Nothing in this section may be construed to:

- Require the Contractor to contract with providers beyond the number necessary to meet the needs of members;
- Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty;
- Preclude the Contractor from establishing measures that are designed to maintain quality of services control costs and are consistent with its responsibilities to members; or
- Allow the Contractor to reimburse FQHCs/RHCs at a rate less than that paid for comparable services provided by non-FQHC/RHC based providers.

For members, with the exception of PCPs as defined in this contract, this may require the Contractor's inclusion of providers who practice or are located outside of the State and/or allowing such members to retain established relationships to preserve continuity of care with non-network providers, including traditional Medicaid providers. The Contractor will be obligated to offer a provider agreement to become a Participating Provider to any such providers. The Contractor may inquire as to member's interest in switching to a closer in-State, in-network provider.

The Contractor will have written agreements with all providers in its network that meet State and Federal requirements. When the Contractor contracts with providers, the Contractor will:

- Not execute provider agreements with providers who have been excluded from participation in the Medicaid/CHIP and/or Medicare programs pursuant to Sections §1128 or §1156 of the Social Security Act or who otherwise is not in good standing with RI Medicaid.
- Have written policies and procedures for the selection and retention of providers. These policies and procedures will not discriminate against providers who service high risk populations or specialize in conditions that require costly treatment.

- The Contractor will have written policies and procedures for the selection and retention of providers that comply with 42 CFR 438.214[xvii] and with the State's policy for credentialing and re-credentialing.
- Not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification as defined by State law, solely on the basis of that license or certification.
- Have policies and procedures to assure providers and office staff comply with the cultural and disability competency requirements
- Give affected providers written notice of the reason for the decision if it declines to include an individual or group of providers within its network;
- Each individual or group provider in the network must has a unique identifier assigned to them.

The Contractor is required to report, to EOHHS, any significant change in its physician/provider network, including its specialist network, within three (3) business days of knowledge of the change. A significant change includes any change that would affect the adequacy of capacity and services, including changes in the Contractor's services, benefits, geographic service area, composition of or payments to its provider network

2.08.02 Contracting with EOHHS Certified Accountable Entities

2.08.02.01 EOHHS Certification of AEs

Fundamental to EOHHS' HSTP program is the certification of Accountable Entities. Certified AEs are eligible to enter into EOHHS approved APM contractual arrangements with EOHHS contracted managed care organizations. MCOs are contractually required to enter into such arrangements with certified AEs. Arrangements with certified AEs must comply with APM requirements and provisions for incentive-based payments through the HSTP as set forth in this Section 2.08.02. The Contractor must submit on an annual basis the APM base Contract with highlighted modifications for the next AE program year for EOHHS review and approval.

EOHHS compliant APM contracts with EOHHS certified AEs shall be based on a performance period that aligns with the State Fiscal Year (July 1 – June 30).

2.08.02.02 Operational Requirements for Management of APM Subcontracts with Accountable Entitles

Upon execution of the subcontract with the AE, the Contractor will undertake activities in support of program operation and management. These activities will include:

- *Implementation of shared management structure* such as a Joint Operating Committee that will meet regularly and not less than bi-monthly to ensure ongoing communication, support of collaborative activities, problem-solving, and ongoing review of progress in performance areas.

Provision of Monthly Member Attribution. On a monthly basis, the Contractor will provide contracted AEs and EOHHS with electronic lists of attributed members, inclusive of identification of additions and deletions. Attribution will be based on the methodology set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

- Provision of Monthly Provider Roster: On a monthly basis, the Contractor will provide EOHHS with electronic list of AE providers, inclusive of identification of additions and deletions.

On a monthly basis, Contractor must provide and review timely, member specific utilization and cost data to AEs. Data shall identify high risk, high utilizer members, provider outlier analysis of high/low performing providers within an AE panel, including any person-level lists generated by EOHHS for specific quality or outcome measures, including, but not limited to the following files:

- Individual level data files for AE Outcome Measures (detailed in ATTACHMENT U)
  - Members Experiencing Mental Illness [MCO] [Time period].csv
  - Preventable ED Visits [MCO] [Time period].csv
- Any additional files as prescribed in the AE Quality and Outcome Implementation Manual
- Any other data reports that are mutually agreed upon to be useful in managing the program, including costs.

The Contractor is required to share a minimum data set (or sets) of claims and attribution information with the contracted AE for its attributed members at a beneficiary-identifiable level. MCOs must use the monthly AE attribution roster to determine the population eligible for the claims extract. Claims for a given performance year should be provided to the AE for attributed members until the contractual paid lag is complete. A full refresh of data going back to the beginning of the performance year, including any retroactive adjustment shall be provided at the beginning and/or end of each Program Year. To enable AEs to validate that their systems are integrating data accurately, control totals should be supplied to the AE with each monthly data set indicating: number of records, total allowed amount for medical and pharmacy claims data set, and number of records and total member months for the eligibility data set. Claim paid amount should be provided on all claims in the data set. Such minimum data set is as applicable to Claims and Non-Claims Based data files as set forth in ATTACHMENT U.

The Contractor is required to develop a methodology for mitigating duplicative claims and coordinate with contracted AEs to ensure duplicative claims are removed from data. Contractors must work with their contracted AEs to determine the most effective methodology for their

unique data systems and interoperability needs for program efficiency.

Prior to transmitting data to AEs, the Contractor must complete the necessary quality checks and review data privacy of members to ensure integrity of data transmitted to the AE for a member's attributed months, including checks for completeness of data outlined in ATTACHMENT U.

The AE must certify that they are requesting this data as a HIPAA covered entity or as a business associate of a HIPAA-covered entity and that the requested data reflects the minimum data necessary for the AE to effectively conduct its health care operations as an AE. This includes activities to:

- Evaluate the performance of AE participants, and AE providers/suppliers;
- Trend utilization and total cost of care performance over time to evaluate longitudinal program impacts;
- Conduct quality assessment and improvement activities; and
- Conduct population-based activities to improve the health of its assigned beneficiary population.

The AE must ensure privacy and security of the data and agree to adhere to any and all applicable State and Federal statutes and regulations relating to confidential health care, behavioral health and substance misuse treatment including but not limited to the Federal Regulation 42 CFR, Part 2; Rhode Island Mental Health Law, R.I. Gen. Laws §40.1-5-26; Confidentiality of Health Care Communications and Information Act, R.I. Gen. Laws §5-37.3-1 et seq, and HIPAA 45 CFR Part 164.

Oversight and Monitoring of Member Access to Care

The Contractor will:

- Ensure that AE Attributed Members are not limited to obtaining services only from AE affiliated Providers
- Ensure Participating AE providers are permitted to make referrals to any provider, as appropriate, regardless of the provider's affiliation with the AE
- Prohibit additional requirements for referrals to providers who are not Affiliated Providers;
- Maintain Attributed Members' access to or freedom of choice of providers;
- Maintain open access to Medically Necessary services; and
- Ensure that AE Attributed Members may obtain emergency services from any provider, regardless of its affiliation with the AE.

- Ensure that AEs implement a contract compliance program to include at least the following:
  - Designated compliance official who is not legal counsel
  - Mechanism for identifying, and addressing compliance problem

Oversight and Monitoring of Quality of Care.

The subcontract with the AE will include a defined and uniform set of performance (per 42 CFR 438.6(c) measures to be incorporated as a factor in the results of any shared savings calculations. Such quality measures will be in compliance with requirements set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners. Subcontracts will clearly delineate such quality measures and the Contractor will monitor performance on quality measures on a periodic basis as appropriate to the measures used.

Financial Reporting and Settlement with AEs.

Subcontracts with AEs will include TCOC shared savings arrangements and will include shared risk arrangements in compliance with Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

Monitoring and reporting to EOHHS

The Contractor will:

- Monitor and report to EOHHS key operational, quality and access metrics specific to appeals, grievances, informal complaints, access to care, and others inclusive of reporting requirements set forth in ATTACHMENT N, SPECIAL TERMS & CONDITIONS.

- Monitor and report to EOHHS on AE Performance, trends and emerging issues within and among AEs on a monthly basis using a standardized reporting form. Such reporting will include material changes in the structure of the AE and any issues within the AEs that are impacting the AE's ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary

2.08.02.03 HSTP and the Medicaid Infrastructure Incentive Program

As part of CFR 42 CFR 438.6, the State has the authority to implement incentive payments to providers. CMS has approved Rhode Island's 1115 Demonstration Waiver enabling EOHHS to proceed with the Health System Transformation Project (HSTP). The HSTP includes financial support in the form of incentives for activities attributable to the establishment of Accountable Entities through Medicaid managed care contracts and Health Work Force Development. Such incentive opportunities will be implemented in compliance 42 CFR 438.6. Associated HSTP incentive payments will be made directly by EOHHS to the Contractor based upon EOHHS

approval of such arrangements and EOHHS determination of satisfactory compliance with such incentive arrangements.

The 1115 waiver provide the financial foundation for the Medicaid Infrastructure Incentive Program (MIIP). Initiation of the MIIP is based upon executed contracts between EOHHS and contracted MCOs and, in turn, upon MCO contracts with EOHHS certified AEs. HSTP and MIIP programs must comply with EOHHS and CMS requirements.

The HSTP is intended to be developed in partnership with MCO contractors. The Contractor will have the opportunity to partner with EOHHS Certified Comprehensive AEs for funding to support the design, development, and implementation of AE infrastructure, skills and capacity. Incentive based funding opportunities for AEs through the Contractor can begin upon EOHHS certification and execution of an EOHHS compliant APM contract between the Contractor and an AE.

This section of the contract describes the MIIP, its component parts, and requirements for the Contractor.

Incentive payments made pursuant to the MIIP are not to be considered part of the medical component of the premium payment made to the MCO.

Incentive payments paid to the Contractor inclusive of payments made by the Contractor to AEs will not be included in any risk/gain share calculations between EOHHS and the Contractor or in any APM total cost of care calculations pertaining to arrangements with AEs.

Total incentive payments inclusive of MIIP incentives, performance goal and/other provider performance-based payments cannot exceed five percent of capitation.

The Contractor will implement the MIIP program in compliance with: *EOHHS Medicaid Infrastructure Incentive Program: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities* available at: www.eohhs.ri.gov. The EOHHS MIIP Incentive Requirements document will be amended annually by EOHHS as program specifications and requirements are refined, as the specific amount of available HSTP funding is determined, as the number of certified AEs and attributable lives becomes more fully known, and in respect to CMS review of HSTP program elements.

Structure of the Medicaid Infrastructure Incentive Program

Total funding available for the Medicaid Infrastructure Incentive Program (MIIP) will be established by EOHHS and set forth in the *EOHHS Medicaid Infrastructure Incentive Program: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities* document. The MIIP includes , the Total Incentive Pool (TIP) which is composed of the AE Incentive Pool (AEIP) and the MCO Incentive Management Pool (MCO-IMP). The *EOHHS Medicaid Infrastructure Incentive Program: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities* will set forth the basis for establishing the maximum potential dollars that could be earned within each of the respective pools.

The maximum potential dollars for each TIP will be determined by EOHHS and be derived in the same manner for each TIP and will be based on a combination of factors. These include: available funds based on federal claiming, number of contracts with certified AEs, and an EOHHS determination of the number of member months to be attributed to the respective AEs for the TIP calculation.

2.08.02.04 Development, Implementation, and Oversight of AEIP Program

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS Requirements are eligible for the Accountable Entity Incentive Program

The Contractor will execute subcontracts with certified AEs that are in compliance with two core EOHHS requirements documents.

- With respect to total cost of care (TCOC) based Alternative Payment Methodologies subcontracts will comply with requirements set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.
- With respect to the AEIP & MCO Incentive Program management Pool (MCO-IP), the Contractor will execute subcontracts that comply with requirements set forth in *EOHHS Medicaid Infrastructure Incentive Program: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities.*

EOHHS intends that development and oversight of the AEIP will provide the basis for a positive partnership between the parties that will advance the goals of the HSTP. The AE will be eligible for receipt of incentive payments based on achievement of clearly defined milestones and performance metrics.

The Contractor will perform key functions in Program Development and in Program Implementation and Oversight of the HSTP AE initiative, including development of the HSTP based AEIP subcontract with AEs and making associated payments. The subcontract with the AE will establish the terms and schedule under which AEs can qualify for and earn performance incentive payments through the AE Incentive Pool (AEIP). The performance requirements for the Contractor to earn performance incentive payments through the MCO-IPare set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

The Contractor requirements are established as set forth below.

- **Execution of TCOC compliant contract**

  Upon certification of an AE by EOHHS, the Contractor and the AE are eligible to enter into an APM compliant contract. As early as the execution of the APM agreement, the Contractor will execute subcontracts with AEs for AEIP incentive program funds to support AEs in developing/enhancing the capacity/tools required for effective system transformation and achieving quality and performance outcomes. Section 2.08.02.05.01 of this Amendment provides further detail on the distribution of AEIP

funds and payment arrangements.

- **Provide a Comprehensive Analytic Profile of the AE's Attributed Population**

  The Contractor will work with each contracted AE to assist in the production of a population specific analysis of the AE's attributed population.
  Within thirty days of execution of an APM agreement with the AE, the Contractor will provide a population specific analysis of the AE's attributed population. This assessment should provide a basis for risk segmentation of the population served by the AE that will help guide project plans. For example, data analyses may identify patterns of gaps in coordinated care for population subgroups such as adults with co-occurring medical and behavioral health needs and/or may identify avoidable inpatient or emergency department utilization in specific geographic areas. AE project plans should then focus on tangible projects within the certification Domain areas, such as IT capability, to identify and track needs or strengthen targeted care management or patient engagement processes.

  The Contractor will convene a review committee to evaluate each proposal. The Contractor's Review Committee, in accordance with EOHHS guidelines, will determine whether the project merits an AEIP incentive contract:

  - Project addresses EOHHS priority areas and allowable uses.
    - Proposal that describes the AE's current strengths and weaknesses in this area and provides clear rationale for work plan and budget
    - Establishes clear interim and final project milestones, timelines, and deadlines; defines projected impacts; and establishes a menu of metrics and measures to be used in determining whether incentives have been earned.
    - Specific activities and metrics presented for the AEIP such that the amount of incentive payment identified is commensurate with the value and level of effort required.
    - Project does not supplant funding from any other source and the funding request is non-duplicative of submissions that may be made to another MCO. While it is not required, the Contractor may work collaboratively with an AE and one or more other MCOs to support a more integrated approach to the project

  The Committee will provide a summary report on Review Committee's recommended action on AE proposals for further refinement or guidance for proceeding to execution of a contract or a contract amendment. The Contractor will provide both the AE and EOHHS with a final determination, based on their MCO Committee review process.

  EOHHS reserves the right to attend meeting(s), as deemed to be necessary by EOHHS, regarding any of the requirements listed above.

- **Execute AEIP Incentive Contracts with Accountable Entities**

The Contractor will execute subcontracts with AEs for AEIP incentive program funds to support AEs in developing and enhancing the capacity and tools required for effective system transformation and for achieving quality and performance outcomes. Subcontracts will specify performance requirements and metrics to be achieved for AEs to earn incentive payments.

The AEIP will be established via a contract or contract amendment between the Contractor and the AE. EOHHS reserves the right to review and approve the terms of incentive contracts with AEs. Incentive contracts will specify performance requirements and milestones to be achieved for AEs and MCOs to earn incentive payments as set forth in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

- **Submit to EOHHS a Schedule of Project Based Metrics and Payment for EOHHS Approval**
    - Within 30 days of an AE being certified by EOHHS, the Contractor must submit for approval to EOHHS project-based metrics and associated incentive payment per each AE contract. Evidence of AE attestation must be included with submission. As described in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners, both the AE and MCOs must agree to a defined set of project-based measures and targets for three AE project as delineated in the AEs HSTP project plan submitted to EOHHS as part of the AEs annual certification. Each project should have at minimum 2 measures per project, one of the three projects shall focus on behavioral health integration and one on social determinants of health. Project-based measure are metrics the AE and MCOs use to track and monitor project implementation and progress. MCO/AE specific performance targets implemented for Performance Year 1 and 2 outcome metrics performance areas can be considered.

- **Assess AE Performance to Determine Whether Incentive Payments Have Been Earned**
    - Contractor will review and evaluate AE progress in achieving AEIP performance targets and determine whether AE performance warrants incentive payments.
    -
    - The Contractor must certify that an AE has met its approved metrics as a condition for its release of associated AEIP funds to the AE.

- **Make payments to the AE's on a timely basis**

2.08.02.05.01 Allocations of AEIP Incentive Opportunities within Subcontract with AE, AEIP Payments by EOHHS to the Contractor, and AEIP Payments by the Contractor to AE

The Contractor will subcontract for and administer an AE Incentive Pool for each subcontracted EOHHS Certified AE.

The AEIP is central to the HSTP providing a contracting and incentive structure for the development of AEs and the MCO-AE relationship. Through the AEIP, certified AEs have the potential to earn incentive payments based on defined performance-based milestones and metrics. The HSTP is based on a series of incentive payments for AEs to advance the transformation of health services.

To be most effective as incentives it is important that incentive payments be meaningful and as closely connected in time to the achievement of milestones as is feasible. To facilitate this EOHHS will make payments to the Contractor on an identified schedule in advance of the projected time of disbursement to the AEs. In turn, the Contractor is required, to make payments to the AEs on a timely basis when agreed upon milestones are achieved. The Contractor will maintain a restricted account for reconciliation of payments received for AEIP payments and payments actually made upon achievement of milestones. Financial reports on the status of AEIP funds will be provided to EOHHS not later than thirty (30) days after the completion of each quarter in a format approved by EOHHS.

The terms of AEIP incentive payments are to be set forth in formal subcontract arrangements between the MCO and the AE. Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners identifies the permissible structure for AEIP incentive payments as well as the payment terms (a) for EOHHS to the Contractor and (b) for the Contractor to AEs.

All EOHHS MCO and AE incentive payments will be made to the MCOs on a quarterly basis for achievement of milestones. Payment is made within 30 days for receipt of completed MCO and AE Performance Milestone reports, including supporting documentation. MCOs must pay AEs within 30 days of receiving AE funds from EOHHS.

	Payment Schedule	
	EOHHS to MCO	MCO to AE
Developmental Milestones: Fixed Percentage Allocations Based on Specific Achievements	EOHHS shall pay MCO for fixed milestones achieved within 30 days of receipt of the quarterly AEIP Milestones Report documenting achievement of the milestone. The first AEIP Milestones Report shall be submitted to EOHHS for the quarter ending September 30th.	Not later than 30 days after receipt of payment from EOHHS, MCO shall make payment for fixed milestones achieved to the AE.

	Payment Schedule	
	EOHHS to MCO	MCO to AE
	Report must be submitted within 30 days of the completion of the quarter.	
Outcome Metrics	EOHHS shall pay MCO for the Outcome Metrics milestone within 30 days of receipt of the Outcome Metrics Report.	Not later than 30 days after receipt of payment from EOHHS, MCO shall make payment for the achieved milestone to the AE.
Developmental Milestones: Variable Percentage Allocations Based on the HSTP Project Plan	Submission of the HSTP Project Plan shall trigger the standard quarterly payment schedule. EOHHS shall pay MCO quarterly based upon the projected timeline for achievement of milestones documented in the HSTP Project Plan. Quarterly payments for milestones targeted for achievement in a quarter shall be made no later than the last day of that quarter.	Within 30 days of approving an AE milestone achievement based on satisfactory evidence, MCO shall make payment for the achieved milestone to the AE.

- **Maintain Separate Account for Each AEIP and Final Settle Up**

The total amount of potential incentive dollars (AEIP) for each MCO-AE specific agreement will be established by EOHHS. Each AEIP will clearly identify the incentive dollars that can potentially be earned by the AE for each specific milestone and project-based metric achieved. For each AEIP relationship, the Contractor will provide EOHHS with a schedule of milestones and project-based measure, projected date of achievement, and associated potential incentive payments. The Contractor will further provide EOHHS with a consolidated schedule of payments for all Contractor-AE AEIP relationships. This will establish the basis for the schedule for EOHHS payments to the Contractor in aggregate and for each AEIP.

The Contractor will have written policies and procedures or receiving and processing AEIP related payments from EOHHS and to AEs including deposit and maintenance in a separate account. The Contractor will establish and maintain a separate accounting for each AEIP. The Contractor will maintain all AEIP funds in a dedicated account, will retain records on funds received and paid out, and will report to EOHHS on related transactions not later than thirty (30) days after the close of each quarter in a format approved by EOHHS. Such account will be available for review by state or federal

auditors if requested.

An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric. Fixed Milestones are an exception to and must be met by close of the performance period for an AE to earn incentive funds. Any funds that were paid by EOHHS to the Contractor and were available to be earned by the AE but unearned in the period will be recorded and retained by the Contractor for potential later payment to the AE during the following contract year.

An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment).

- **"Reporting to EOHHS** on the payments to AEs
  - Not later than thirty (30) days after the close of each quarter the Contractor will submit to EOHHS reports that document progress on identified milestones and metrics for each AE.
  - The Contractor must certify in this report that an AE has met its approved milestones/metric as a condition for MCO payment of associated AEIP funds to the AE. The Contractor will, in each report, document progress on identified milestones and metrics for each AE, specific dollar allocation for each milestone, and the amount earned by milestone.
  - EOHHS reserves the right to suspend payments to the Contractor in the event of non-compliance with requirements and to recoup all unspent funds."

- **Final Settle up with EOHHS**

Within forty-five (45) days of the point where the AE can no longer earn AEIP funds (for example one year after the end of last quarter of the final Program Year, or sooner in the event of a termination of an arrangement with an AE or with the Contractor) the Contractor will provide a final accounting of all EOHHS AEIP payments. Any unpaid, unearned incentive payment funds that have been paid to the Contractor in an AEIP payment will be returned to EOHHS at the same time.

2.08.02.05 MCO Incentive Program Management Pool (MCO-IMP)

1. **MCO Incentive Program Management Pool (MCO-IMP)**

As set forth in Section 2.08.02.04 (AEIP Program Development, Implementation, and Oversight of AEIP Program), the Contractor is responsible for effective implementation and management of the AE program, including oversight and actions to promote successful

AE performance. EOHHS will establish the maximum potential MCO-IMP prior to the start of the TCOC performance period. The MCO-IMP shall be established in accordance with the requirements articulated in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

Each MCO-IMP is specific to the relationship between the Contractor and an AE. Based on satisfactory Contractor performance, the Contractor will earn its share of the MCO-IMP. The TIP represents the total potentially available pool and is not reduced in the event that incentives are not fully earned by one party or another. Section 2.08.02.05 sets forth performance requirements of the Contractor in the development and implementation of the AEIP program.

The basis for MCO-IMP payments is established in Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners. Payments by EOHHS to the Contractor will be made quarterly pursuant to the MCO-IMP based on the Contractor's reporting on completion of tasks and EOHHS review. The Contractor will present a summary report of performance of these activities at the conclusion of each calendar quarter.

On a quarterly basis, the Contractor will submit a report for each Contractor-AE relationship identifying its milestones and metrics achieved as set forth in the table above. Such report will also include a request for payment by EOHHS for respective components of the MCO-IMP for each Contractor-AE relationship. Based on EOHHS review and approval of the Contractor's demonstration of achievement of milestones the EOHHS will make payment to the Contractor within thirty (30) days of submission of the report.

2.08.02.06 Operational, Quality, and Financial Reporting for Accountable Entity Initiative

The Contractor will fully comply with the operational, quality, and financial reporting requirements as established by the EOHHS for the AE Initiative. The Contractor's submission of AE-related reporting must comply with requirements outlined in Section 2.13.01 (General), Section 2.13.11 (Certification of Data), and Section 2.16.03 (Financial Data Reporting).

Upon the request of EOHHS, the Contractor will submit: a) an electronic list of Comprehensive AEs that are under subcontract to the Health Plan; b) a spreadsheet that outlines the Contractor's number of Medicaid attributed lives by AE, using the EOHHS APM reporting; and c) an electronic copy of the Contractor's written plan for monitoring and oversight of its AE subcontractors.

2.08.03 Primary Care Providers (PCPs)

2.08.03.01 PCP Responsibilities

The PCP must serve as the member's initial and most important point of interaction with the Health Plan network. As such, PCP responsibilities must include at a minimum:

- Serving as the member's Primary Care Provider (PCP) and medical home
- Willing and able to provide the level of care and range of services necessary to address the medical and behavioral needs of members, including those members with chronic conditions
- Provide overall clinical direction and serve as the central point for the integration and coordination of care
- Making referrals for specialty care and other Medically Necessary services, both in- and out-of-plan
- Maintaining and sharing a current medical record for the member in accordance with professional standards and encouraging the member to participate in Current Care
- Serve as the general care manager and refer members for specialized care management services, when appropriate

Although PCPs must be given responsibility for the above activities, the Contractor also agrees to retain responsibility for monitoring PCP actions to ensure they comply with the Contractor and Medicaid managed care program policies.

2.08.03.02 Eligible Specialties

The Contractor agrees to limit its PCPs to licensed, board-certified, eligible, or trained Medical Doctors and Doctors of Osteopathy.

PCPs may also be Advanced Practice Practitioners under certain circumstances as provided for in Section 2.08.03.05, Certified Nurse Practitioners as PCPs.

The Contractor will include NCQA certified Patient-Centered Medical Homes (PCMH) in its network that serve as primary care providers. PCMHs provide and coordinate the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes.

The Contractor will have a network of home-based primary care providers. The Contractor will encourage and promote the utilization of Telehealth in coordination and collaboration with home-based primary care providers.

2.08.03.03 PCP Teams

If the Contractor's primary care network includes institutions with accredited primary care residency training programs, it may use PCP teams, comprised of residents and a supervising faculty physician, to serve as a PCP. The Contractor will organize its PCP teams so as to ensure continuity of care to members and must identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and the physician who is accountable as the PCP. Teams will be small in size and team members will be assigned for sufficient duration to maintain patient continuity.

2.08.03.04 PCP Sites

If the Contractor's primary care network includes Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs), it may designate either type of site as a PCP. In both instances, the Contractor will organize its PCP sites so as to ensure continuity of care to members and will identify a "lead physician" within the site for each member and the physician who is accountable as the PCP.

2.08.03.05 Certified Nurse Practitioners as PCPs

The inclusion of the following Advanced Practice Practitioners Certified Nurse Practitioners, and/or Physician Assistants - is permitted and encouraged. EOHHS recognizes the ability of Advanced Practice Practitioners to provide Primary Care to members. EOHHS also recognizes that some members may wish to designate an Advanced Practice Practitioner as their PCP. Therefore, the Contractor may use Advanced Practice Practitioners as PCPs with the following conditions:

2.08.03.05.01 Advance Practice Registered Nurses (APRN)

EOHHS recognizes the ability of Advanced Practice Practitioners to provide Primary Care to members. EOHHS also recognizes that some members may wish to designate an Advanced Practice Practitioner as their PCP. APRNs, depending upon their level of professional training and experience, may perform health care services consistent with their expertise and scope of practice and may serve as a primary or acute care provider of record.

Therefore, the Contractor may use Advanced Practice Practitioners as PCPs with the following conditions: Hold a current Rhode Island license as an Advance Practice Practitioner (Certified Nurse Practitioner) or privilege to practice and shall not hold an encumbered license or privilege to practice as an RN in any state or territory.

2.08.03.05.02 Physicians Assistants

Physician assistants may perform those duties and responsibilities consistent with the limitations

of R.I. Gen. Laws § 5-54-8, including prescribing of drugs and medical devices, that are delegated by their supervising physician(s). Physician assistants may request, receive, sign for and distribute professional samples of drugs and medical devices to patients only within the limitations of R.I. Gen. Laws § 5-54-8. Notwithstanding any other provisions of law, a physician assistant may perform health care services when such services are rendered under the supervision of a licensed physician.

2.08.03.06 Member-To-PCP Ratios

The Contractor agrees to assign no more than fifteen hundred (1,500) members to any single PCP in its network. For PCP teams and PCP sites, the Contractor agrees to assign no more than one thousand (1,000) members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to three thousand (3,000) members.

2.08.03.07 In-Network Self-Referrals

The Contractor agrees to have written policies and procedures that permit members at a minimum to self-refer for one annual and up to five (5) GYN/Family Planning visits annually and for sexually-transmitted (STD) services, without obtaining a referral from the Primary Care Provider.

These policies and procedures must also include that members may see out of network providers for these services.

2.08.03.08 Transitioning Between Non-Network and Network Providers for Medical and Behavioral Health

The State recognizes that members upon enrollment in a Health Plan may transition between non-network and network providers to receive needed health care services (medical, behavioral and substance use disorder). The Contractor may require that non-network providers possess appropriate licensure, certification, or accreditation as required by the NCQA. This can occur when members first enroll in a Health Plan, when members change Health Plans, or at other times. To ensure continuity of care, the Contractor agrees to have written policies and procedures for transitioning between network and non-network providers.

The Contractor will routinely document the frequency of use from non-network to network providers in a format acceptable to EOHHS on an agreed upon schedule. These policies and procedures must contain a provision allowing members to continue seeing out-of-network providers for up to six (6) months after the member's enrollment into the Health Plan. Existing prior authorizations may require the Contractor to extend the six (6) month transition period. At the end of such period, in order to require that member transition to an in-network provider, the Contractor must offer a provider with comparable or greater expertise in treating the needs of members.

The Contractor will ensure there is no cost to the member for the transfer of medical records during the transition period and thereafter, for efficient and seamless transfer of clinical care from one provider to another (in-network or out-of-network, Primary or specialty care, including behavioral health and substance use disorder).

2.08.04 Behavioral Health and Substance Use Disorder Providers

2.08.04.01 Provider Mix

The Contractor agrees to include a mix of behavioral health providers in its network to ensure that a broad range of treatment options representing a continuum of care is available to both children and adults. The behavioral health provider network will at least include Psychiatrists, Clinical Psychologists, Psychiatric Nurses, licensed Social Workers, adequate network of buprenorphine waivered physicians and providers licensed by the Departments of Children, Youth and Families (DCYF), and the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH).

The network must include providers experienced in serving adults and children, low income populations, subspecialists or specialty providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (behavioral health and substance use) in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network will also recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated. The Contractor will include all BHDDH-licensed Community Mental Health Centers (CMHCs) in its network. The Contractor will include Evidence Based Practice/ABA providers in the network.

2.08.04.02 In-Network Self Referrals

The Contractor agrees to have written policies and procedures that permit members to self-refer for in-network behavioral health services, rather than obtaining a referral from their Primary Care Provider. These policies and procedures must identify timely access standards for behavioral health services. The Contractor will notify members of the right to access behavioral health services without a referral from their PCP. The Contractor will establish provisions for the coordination of this care with the PCP that takes into account patient confidentiality requirements.

2.08.05 Substance Use Providers

2.08.05.01 Provider Composition

The Contractor will include licensed substance use disorder treatment programs and licensed substance use disorder professionals in its substance use disorder provider network. The network

will include providers experienced in serving low-income populations, persons with poly-pharmacy and dual diagnosis in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network will also recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated. In order to accomplish this, the Contractor may ease customary credentialing standards provided this does not jeopardize the Contractor's licensure or accreditation status. The Contractor will assure access to confidential substance use disorder treatment services for minors as provided for in Chapter 14-5-4 of the RI General Laws.

The Contractor will include all BHDDH-licensed substance use disorder providers in its network unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without contracting with all licensed BHDDH-licensed substance use disorder providers. The Contractor will work with all Centers of Excellence certified by BHDDH to be providers under the Governor's Opioid Overdose Prevention and Intervention Task Force.

2.08.05.02 In-Network Self Referrals

The Contractor agrees to have written policies and procedures that permit members to self-refer for in-network substance use disorder services, rather than obtaining a referral from their Primary Care Provider. These policies and procedures must identify timely access standards for substance use disorder services. The Contractor will notify members of the right to access substance use disorder services without a referral from their PCP. The Contractor will establish provisions for coordination of this care with the PCP that takes into account patient confidentiality requirements.

2.08.05.03 Transitioning between Non-Network and Network Providers

EOHHS recognizes that members may need to, at times, transition between non-network and network providers to continue to receive needed substance use disorder services. This can occur when members first enroll in a Health Plan, when members change Health Plans, or at other times. The Contractor agrees to have written policies and procedures for transitioning members between non-network and network providers to assure continuity of care, including paying for one or more transition visits with a non-network provider.

2.08.06 Children's Behavioral Health Services

The Contractor will develop and maintain a network of behavioral health providers to deliver services specific to the needs of children. See ATTACHMENT O for further information.

2.08.07 Physician/Provider Specialists

The Contractor will establish and maintain a network of contracted physician/provider specialists that is adequate and reasonable in number, specialty type, and in geographic distribution to meet the needs of its members (adult and children) without excessive travel requirements. Because of the large number of physician/provider specialties that exist, the Contractor is not required to maintain specific member-to-specialist physician/provider ratios. However, the Contractor agrees to provide adequate access to physician specialists for PCP referrals and contract with specialists in sufficient numbers and locations to ensure specialty services can be made available in a timely manner.

The Contractor will ensure that if its provider network is unable to provide medically necessary services, covered under the contract, to a particular member, the Contractor must adequately and timely cover these services out of network for the member, for as long as the Contractor's provider network is unable to provide the services. Contactor will require out-of-network providers to coordinate with them for payment and ensures the member will be held financially harmless.

2.08.08 Electronic Visit Verification (EVV)

As a requirement of the 21st Century Cures Act, EOHHS requires implementation of EVV.

EVV is a system established to enhance program efficiencies and quality assurance for various in-home and community-based care services administered by EOHHS and the managed care organizations. EVV is an in-home visit scheduling, tracking and billing system that uses telephony-based technology and GPS tracking to capture time and service information about home and community-based service visits. EVV is intended to employ controls within the delivery of home and community-based services to ensure quality of care, program efficiency and quality assurance for various in home and community-based services. The Contractor will implement and operationalize an EVV program as defined by EOHHS. EVV is intended to employ controls within the delivery of home and community-based services to ensure quality of care, program efficiency and quality assurance for various in home and community-based services.

EOHHS has delegated its authority to an EVV vendor to administer the collection of data for the program. MCOs will be required to transfer data, including member specific information, and work cooperatively in partnership with the EVV vendor and EOHHS.

2.08.09 FQHCs/RHCs

The Contractor shall include FQHCs and RHCs in its network unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without contracting with FQHCs or RHCs.

2.08.10 Department of Health Laboratory

The Rhode Island Department of Health (RIDOH) operates a reference laboratory (State Health

Laboratories) and relies on this laboratory to help monitor events of lead poisoning and other reportable diseases throughout the State. To assist in this surveillance process, the Contractor agrees to require its network providers to submit to the State Health Laboratories specimens for HIV testing and mycobacteria (TB) analysis as well as blood lead samples as described in the Reporting and Testing of Infectious, Environmental, and Occupational Diseases (216-RICR-30-05-01). The Contractor also agrees to submit specimens from suspected cases of measles, mumps, rubella and pertussis or other infection diseases when required by the State to facilitate investigations of outbreaks.

2.08.11 Title X Providers

The Contractor is encouraged to include Title X delegate agency providers in its network to serve individuals to provide required non-medical services and supports.

2.08.12 School-Based Clinics

The State considers school-based clinics to be an important part of the health care delivery system for Rhode Island's children. In particular, the State believes that primary and preventive health services are not currently being delivered effectively to Rhode Island's adolescent population and that school-based clinics may help to address this problem. The Contractor is required to include all State-approved school-based clinics in its network for delivery of Medicaid-covered services available at the school-based clinics by the effective date of this Agreement.

2.08.13 Mainstreaming

The State considers mainstreaming of members into the broader health delivery system to be an important program objective. The Contractor agrees that all of its network providers will accept members for treatment. The Contractor agrees to have policies and procedures in place such that any provider in its network who refuses to accept a member for treatment cannot accept non-members for treatment and remain in the network. The Contractor also agrees to accept responsibility for ensuring that network providers do not intentionally segregate members in any way from other persons receiving services. A violation of these terms may be considered a material breach and any such material breach may be grounds for termination of this Agreement under the provisions of Section 3.10.01 (Termination for Default).

2.08.14 Selective Contracting

Notwithstanding the provisions of Section 2.08.01, the Contractor is expected to utilize selective contracting and/or preferred provider initiatives for non-primary care and non-urgent services in order to secure the best price for services while maintaining quality and timely access.

2.08.15 Provider Network Lists

The Contractor agrees to provide EOHHS quarterly with a list of all its participating providers, including its behavioral health and substance use disorder providers, with whom regular referral arrangements exist. This list must include a separate list of PCPs who have adequate capacity to accept members. In addition, a list will be provided quarterly that includes designation of language capability of the provider and physical accessibility of the provider's location, as well as applicable addresses and telephone numbers.

2.08.16 Network Changes

The Contractor agrees to notify EOHHS monthly of any changes in its network's composition. The Contractor also agrees to notify EOHHS within three (3) calendar days of any changes to the composition of its provider network that materially affects the Contractor's ability to make available all capitated services in a timely manner. The Contractor agrees to have procedures to address changes in its network that negatively affect the ability of members to access services. The Contractor agrees to follow policies and procedures contained in the attached "Provider Terminations and Network Changes Policy V1.2". 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 give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

The criteria the Contractor employs in the creation of selective provider networks must be transparent to EOHHS and must be reviewed and approved by EOHHS prior to the implementation of network changes. If a Selective Network is to be created, EOHHS and the Contractor will work together in good faith to come to mutual agreement on Selective Contracting concepts prior to the Contractor's implementing a Selective Contracting initiative.

The Contractor will notify EOHHS in writing of any actions undertaken to terminate or suspend a practitioner from the Contractor's network due to quality, Medicaid fraud or abuse, or integrity, within ten (10) calendar days. Pursuant to 42 CFR 438.10(f)(1), the Contractor will make a good faith effort to provide written notice of a terminated provider, within fifteen (15) calendar days of issuing the termination, to any member who received primary care from or was seen on a regular basis by the terminated provider.

2.08.17 Provider Discrimination

The Contractor may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor

declines to include an individual or groups of providers in its provider network, it will provide the affected providers with written notice of the reason for its decision.

2.08.18 Networks Related to Indians

The Contractor will permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services. The Contractor is required to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers. The Contractor will ensure that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. The Contractor must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45[xviii] and 42 CFR 447.46.

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 provider 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 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[xix], the 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 the Contractor's own facilities or through arrangement, with other providers. The Contractor agrees that services will be made available immediately for an emergent medical condition including a mental health or substance use disorder condition. In accordance with 42 C.F.R. §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 C.F.R. §438.114(d)(3) 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)[xx], 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 twenty-four (24) hours
Routine Care Appointment	Within thirty (30) calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	Thirty (30) calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within ten (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 1.90 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 C.F.R. §422.113(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 C.F.R. §422.113(c).

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 will 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, the Contractor will 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 will have policies and procedures whereby the member is ensured facilitated and timely access to such principal coordinating physician. Where this is the case, the Contractor will 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)[xxi], 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) and produce a treatment plan as appropriate for the member's condition and identified needs.

2.09.10 EOHHS Affordability Standards

The Contractor will comply with the Affordability Standards issued by the RI Executive Office of

Health and Human Services (EOHHS). The Affordability Standards aim to improve the affordability of health in the State by requiring companies issuing health insurance to: (1) expand and improve primary care infrastructure, (2) adopt patient centered medical homes, (3) support Current Care the State's information exchange, and (4) work toward comprehensive payment reform across the delivery system.

2.09.11 High Utilizers

As part of the high utilizer initiative, EOHHS appreciates the importance of sharing high utilizer registries with providers in a secure and easily accessible manner. EOHHS anticipates the Contractor will work within its provider community to design thoughtful data sharing arrangements that are more impactful than the use of the provider portals. Additionally, EOHHS anticipates that the Contractor will bolster contracts with providers to include standards for using high utilizer data information and assisting members with hospital discharge. The Contractor is required to coordinate with PCMH practices and other providers.

2.10 MEMBER SERVICES

2.10.01 General

The Contractor will establish and maintain a member services function to timely and adequately respond to member's questions, comments and inquiries. The Contractor agrees to staff a Member Services function, including a toll-free telephone line, to be operated at least during regular business hours (8AM to 6PM including lunch hours). The Contractor's member services function will operate in alignment with the State of Rhode Island's holiday schedule. When the State of Rhode Island is open for business, member services will be operational.

The Contractor will develop policies and procedures that address staffing, training, hours of operations, access and response standards for member service. Member service line should be adequately staffed to provide appropriate and timely responses regarding the following:

Explaining to members the operation of the Health Plan, including the role of the PCP and what to do in an Emergency or urgent medical situation

Ordering member materials such as Handbooks and Provider Directories

Assisting members in the selection of a PCP

Assisting members with questions regarding benefits and how to access services

Assisting members to make appointments and obtain services

Arranging interpreter services

Handling member complaints, grievances and appeals

Assisting members with coordination of out-of-plan services

As part of its Member Services function, the Contractor will have an ongoing program of member education that take into account the multi-lingual, multi-cultural nature of the population.

As part of its Member Services function, the Contractor will have a Member Advisory Committee for all lines of business. At a minimum, this Member Advisory Committee will meet on a quarterly basis.

The Contractor will establish and monitor performance standards for member service functions. As part of its Member Services function, the Contractor will have an ongoing program of member education. The member education program will include a quarterly provider newsletter as described below.

- The Contractor will at a minimum distribute on a quarterly basis a newsletter to members which is intended to educate members on benefits and services, health education, proper utilization of services, importance of screenings and other preventive services, information on appropriate prescription drug usage and any other topics relative to the members.
- The Contractor will submit newsletters to the EOHHS for prior review and approval before distribution.

Call Center Performance:

- The Contractor must answer eighty percent (80%) of all Member telephone calls within thirty (30) seconds or less. Liquidated damages in the amount of Five Hundred dollars ($500) per month for each month the Contractor fails to answer eighty percent (80%) of all calls within thirty (30) seconds (does not include initial announcement).

- The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the called following the interactive voice response (IVR) system, touch tone response system or recorded greeting before reaching a live person. Liquidated damages in the amount of Two Hundred and Fifty dollars ($250) per month for each month the average time on hold, for calls placed on hold after two (2) minutes of being initially answered exceeds two (2) minutes.

- The Contractor must limit the disconnect rate of all incoming calls to five (5%) percent. Liquidated damages in the amount of Five Hundred dollars ($500) per month for each month the average number of calls abandoned is greater than or equal to five percent (5%).

- The Contractor must have a process to measure the time from which the telephone is answered to the point at which a Member reaches a live person capable of responding to the Member's questions in a manner that is sensitive to the Member's language and cultural needs.

2.10.02 Toll-Free Telephone Number

The Contractor agrees to maintain a toll-free member services telephone number. While the full member services function will not be required to operate after regular business hours (between 6 PM and 8AM) this or another toll-free telephone number of the Contractor must be staffed twenty-four (24) hours per day to provide prior authorization of services, including pharmacy, during evenings and on weekends.

The Contractor will ensure that TYY/TDD services and foreign language interpretation are available when needed by a member who calls the member services telephone number.

2.10.03 Annual Notification

Once a year, the Contractor must notify members in writing of their rights to request and obtain the information listed below:

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's services area, including those not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
- Any restriction on the member's freedom of choice of network providers
- Member rights and protections, including those specified in 42 CFR 438.100[viii]
- Notify all members of their disenrollment rights
- Information on grievance, appeal, and State Fair Hearing procedures, including applicable time frames and the information specified in 42 C.F.R. § 438.10(g)(2)
- The amount, duration, and scope of benefits available under this Agreement in sufficient detail to ensure that members understand the benefits to which they are entitled
- Procedures for obtaining benefits, including authorization requirements
- The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers
- The extent to which, and how, after-hours and emergency coverage are provided, including:

- What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definition in 42 CFR 438.114(a)[v]
- The fact that prior authorization is not required for emergency services.
- The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
- The locations of any emergency settings and other locations at which providers and hospital furnish emergency services, urgent care and Post-Stabilization Care Services covered under this Agreement.
- The member has a right to use any hospital or other setting for emergency care.

- The Post-Stabilization Care Services rules set forth in 42 CFR 422.113(c)**Error! Bookmark not defined.**
- Policy on referrals for specialty care and for other benefits not furnished by the member's PCP
- Cost-sharing, if applicable
- How and where to access any benefits that are available under the Medicaid State Plan, but are not covered under this Agreement, including any cost-sharing and how transportation is provided. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. EOHHS must provide information on how and where to obtain the service.
- Advance directives, as set forth in 42 C.F.R. §438.3(j)
- Additional information that is available on request, including information on the structure and operation of the Health Plan and physician incentive plans as set forth in 42 C.F.R. §438.3(i), §422.208 and §422.210

The Contractor agrees to submit to EOHHS for prior review and approval the written materials to be used to fulfill these requirements in accordance with *Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs.*

2.10.04 Cultural Competency

As required by 42 CFR 438.206[xvi], the Contractor will participate in EOHHS's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, diverse cultural and ethnic backgrounds, and disabilities regardless of gender, sexual orientation or gender identity.

The Contractor must ensure that services are provided in a culturally competent manner to all members. Culturally competency is the ability of providers and organizations to effectively deliver healthcare services that meet the social, cultural and linguistic needs of members.
Specifically, the Contractor will:

1. Develop policies and procedures for the provision of language assistance services which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats.

2. Will provide language and cultural competence training to all employees, subcontractors and providers. Training should include the potential impact of linguistically and cultural barriers on members obtaining services.

3. Must give the concerns of members related to their racial and ethnic minority status full attention beginning with the first contact with a member, continuing throughout the care process, and extending to evaluation of care;

4. Must make interpreter/translation services available when language barriers exist and are made known to the Contractor, including the use of sign interpreters for members with hearing impairments and the use of Braille for members with vision impairments; and

5. As appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its member population.

2.11 PROVIDER SERVICES

The Contractor will establish and maintain a provider services function to timely and adequately respond to providers' questions, comments and inquiries. The Contractor agrees to staff a Provider Services function, including a toll-free telephone line, to be operated at least during regular business hours.

The Contractor will develop policies and procedures that address staffing, training, hours of operations, access and response standards for provider service. Provider service line should be adequately staffed to provide appropriate and timely responses regarding the following:

- Eligibility and Benefits
- Prior Authorizations, referral requirements, care coordination and network questions
- Claims payment issues, appeal requests, complaints and an escalation path, if requested
- Assisting providers with questions concerning member eligibility status
- Assisting providers with Health Plan prior authorization and referral procedures
- Assisting providers with claims payment procedures
- Handling provider complaints
- Assisting with care management

The Contractor will establish and monitor performance standards for provider service functions. As part of its Provider Services function, the Contractor will have an ongoing program of provider education concerning the benefits and the needs of the member population covered under this Attachment. The provider education program will include a quarterly provider newsletter and will communicate, at least annually, changes in benefits, member's rights and responsibilities.

The Contractor will require providers to report any changes in address or telephone numbers at least thirty (30) days prior to the change occurring.

The Contractor will also require providers for advance notification in the event that the practice is dissolved or sold. The Contractor will also impose a requirement that the practice's management must notify the Contractor in the event that a provider leaves the practice or expires.

2.11.1 Provider Manual

The Contractor will develop a provider manual and make available to all contracted providers The Contractor may distribute the provider manual electronically (i.e. via website) as long as providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge.

The provider manual at a minimum should contain the following information:

1. Description of the RI Medicaid Program and covered service
2. Medical necessity standards and clinical practice guidelines
3. PCP responsibilities
4. Coordination and transition of care expectation
5. Prior authorization and referral requirements
6. Members' rights and responsibilities
7. Reporting suspected fraud, waste, abuse
8. Medical record standards
9. Payment policies
10. Important phone numbers
11. The Contractor's or the Contractor service standards (access and availability)
12. 24-hour coverage requirements
13. Complaints, Grievance and appeal procedures

2.12 MEDICAL MANAGEMENT AND QUALITY ASSURANCE

2.12.01 General

The Contractor agrees to comply with all Office of the Health Insurance Commissioner utilization review standards for external appeals, in addition to specific standards described in this section. A Health Care Provider who has the appropriate clinical expertise in treating the member's condition or disease may make a decision to deny a service authorization request or to authorize a service on the basis of Medical Necessity in an amount, duration or scope that is less than requested.

As specified in 42 CFR 438.700(b)(1) intermediate sanctions may be imposed should the Contractor fail substantially to provide medically necessary service that it is required to provide, under law or under its contract with EOHHS, to an enrollee covered under this contract.

2.12.02 Medical Director's Office

The Contractor will designate a Medical Director responsible for the development, implementation, and review of the internal quality assurance program (QAP). The Medical Director will have adequate and appropriate experience in successful QA programs and be given sufficient time and support staff to carry out the Health Plan's QA functions. The Medical Director will be full-time and be employed by the Contractor. The Contractor may use assistant or associate Medical Directors to help carry out the responsibilities of this office.

The qualifications and responsibilities will include, but need not be limited to, what follows below. Specifically, the Medical Director will:

- Be licensed to practice medicine in the State of Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty
- Be responsible for the Contractor's UR and QA Committees, direct the development and implementation of the Contractor's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
- Be responsible for the development of staff education about the Contractor's policies and procedures on advanced directives
- Be responsible for the development of medical practice standards and protocols for the Contractor
- Oversee the investigation of all potential quality of care problems, including but not limited to member-specific occurrences of possible Health Care-Acquired Conditions and Other Provider-Preventable Conditions in accordance with 42 C.F.R. §447.26, §434.6(a)(12), §438.3(g), and Section 2703 of the Patient Protection and Affordable

Care Act , and possible hospital acquired conditions and recommend development and implementation of corrective action plans.

- Be responsible for the development of the Contractor's medical policies, including the implementation and oversight of evidence-based practice guidelines.

- Be responsible for the Contractor's referral process for specialty and out-of-plan services

- Be involved in the Contractor's recruiting and credentialing activities

- Be involved in the Contractor's process for prior authorizing and denying services

- Be involved in the development and oversight of the Contractor's disease management programs

- Be involved in the Contractor's process for ensuring the confidentiality of medical records/client information

- Be involved in the Contractor's process for ensuring the confidentiality of sexually transmitted infection (STI) appointments and mental health and substance use appointments

- Serve as a liaison between the Contractor and its providers and communicate regularly with the Contractor's providers, addressing areas of clinical relevance including but not limited to:

    - The Contractor's utilization management functions
    - The Contractor's prescription and over the counter drug formulary for Medicaid enrollees
    - Disease management and health promotion programs offered by the Contractor
    - Any prior authorization (PA) requirements
    - Clinical practice guidelines
    - Quality indicators, such as the Contractor's performance on HEDIS® and CAHPS® measures

- Serve as the Contractor's representative on the EOHHS Medical Care Advisory Committee.

- Serve as the Contractor's senior clinical officer, participating in the health plan's development of Alternative Payment Methodologies (APM), including any total cost of care and related quality metrics.

- Provide clinical executive leadership as the Contractor analyzes the outcomes of quality metrics for any Alternative Payment Methodologies, including Accountable Entities.

- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of health care benefits

- Be available to the Contractor's medical staff on a daily basis for consultation on referrals, denials, complaints, and problems

- A change in Medical Director requires the Contractor to notify EOHHS of change and transition plan as soon as possible but no later than five (5) business days after MCO becomes aware of staffing change. Transition plan must be included with notification to EOHHS.

2.12.03 Utilization Review and Quality Assurance (UR/QA)

2.12.03.01 General

The Contractor agrees to have written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its network. Such policies and procedures will:

- Conform to 42 CFR 438.340 and 42 CFR 438.210

- Assure that the UR and QA Committees meet on a regular schedule

- Provide for regular UR/QA reporting to the Contractor management and the Contractor providers, including profiling of provider utilization patterns

2.12.03.02 Utilization Review

The Contractor agrees to have written utilization review policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, drug utilization, and retrospective review of claims. As part of its utilization review function, the Contractor also agrees to have processes to identify utilization problems and undertake corrective action. As part of this function, the Contractor will have a structured process for the approval or denial of covered services. This will include, in the instance of denials, formal written notification to the member and the requesting or treating provider of the denial, its basis and any applicable appeal rights and procedures. Additionally, the Contractor will send formal written notice to members for denials of out-of-network services if the services were delivered six (6) months after the member's enrollment into the Health Plan and there is no existing prior authorization requiring the Contractor to extend the six (6) month transition of care period.

The Contractor will provide standard authorization decision within fourteen (14) calendar days of the request for authorization. The timeframes for standard authorization decisions may be extended

by fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and the Contractor can demonstrate how the extension is in the member's interest. The Contractor will comply with all timely and adequate notice requirements as specified in 42 CFR 438.404(c).

The Contractor is permitted to conduct utilization review and place appropriate limits on services supporting member with ongoing or chronic conditions so long as services are authorized in a manner that reflects the member's ongoing needs for such services and supports. The Contractor may also conduct utilization review for family planning services but only in a manner that protects the member's freedom to choose their method of family planning.

The Contractor must make an expedited service authorization decision in cases where the member's provider has determined that the fourteen (14) day authorization timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function. The Contractor will resolve expedited authorizations within seventy-two (72) hours. after receipt of the request for service. The Contractor may extend the seventy-two (72) hour expedited authorization by up to fourteen (14) calendar days if the member requests an extension, or if the Contractor can justify a need for the additional time and the extension is in the member's best interest.

The Contractor will demonstrate to EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The Contractor will define service authorization in a manner that at least includes an enrollee's request for the provision of services as required by 42 CFR 431.210.

The Contractor will have policies and procedures for conducting utilization review to authorize non-hospital-based detoxification services. These policies and procedures should allow for a presumptive authorization period of three (3) days for admissions into a detoxification facility. The provider should seek to obtain additional authorization for these services during this three (3) day presumptive authorization period. EOHHS and/or its designee and the Contractor will monitor the frequency and appropriateness of use of this three (3) day presumptive authorization period and re-assess after the first six (6) months of the effective date of this Agreement. These policies and procedures are subject to EOHHS review and approval and should be comparable to criteria established by the American Society of Addiction Medicine (ASAM).

The Contractor is required to offer all levels of residential substance use treatment, as specified by the American Society of Addiction Medicine (ASAM), and further described in ATTACHMENT O & ATTACHMENT P .

The Contractor will modify level of care guidelines for substance use residential treatment to accommodate the special needs of Medicaid beneficiaries recently discharged from a correctional facility. The Contractor will modify all applicable policies and procedures to reflect these requirements and submit to EOHHS for review and approval.

The Contractor is exempt from conducting all utilization review activities for civil and criminal court-ordered mental health and substance use treatment, where the treatment length of stay and other requirements are specified in the court order. Where such specificity does not exist in the court order, utilization review activities should occur.

The Contractor will have policies and procedures for conducting utilization review to authorize residential substance use treatment services. These policies and procedures should allow for the provider to conduct the initial assessment that is utilized to determine prior authorization, up to, but no greater than, two weeks prior to admission date to the facility.

To ensure adequate duration of care, prior authorizations will certify that the Member can receive treatment for a minimum of two weeks. This does not preclude the Contractor from conducting utilization review during the two-week authorization to determine if the member continues to require residential substance use treatment services based on medical necessity criteria. These policies and procedures are subject to EOHHS review and approval and should be comparable to criteria established by the American Society of Addiction Medicine (ASAM).

The Contractor may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to facilitate discharge planning, consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary care. These direct discussions may be used to assess the medical and/or mental health status of a patient.

The Contractor must maintain written policies and procedures that cover the language and format of notices of adverse actions:

- Written notice must be translated for individuals who speak prevalent non-English languages, as defined by EOHHS per 42 C.F.R. § 438.10(a).
- Notice must include language clarifying that oral interpretation is available for all languages and how to access it.
- Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration for those with special needs.
- Enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

The Contractor will establish a prior authorization process for Adult Day Health Services that includes a review of minimum standards of eligibility as defined below:

1. The member must have a medical or mental dysfunction that involves one or more physiological systems and indicates a need for nursing care, supervision, therapeutic services, support services, and/or socialization.
2. The member must require services in a structured Adult Day Health Setting.
3. The member must have personal physician that can attest to the member's need.

4. The Contractor will ensure that its Adult Day Health Service providers complete health assessment for admission; establish an oversight and monitoring process for the program that involves a licensed nurse; and provides standard and ad hoc reporting on this project.

The Contractor must establish this process and provide evidence of compliance to EOHHS upon request.

Contractor must comply with Treatment of Hepatitis C Prior Authorization Guidelines authorized on March 1, 2021 by EOHHS.

2.12.03.02.01 Drug Utilization Review

The Contractor shall operate a Drug Utilization Review Program (DUR) that complies with all of the requirements contained in Section 1927(g) of the Social Security Act. In addition, the Contractor shall comply with all of the requirements contained in 42 C.F.R. part 456, Subpart K, as if the requirements applied to the Contractor instead of the State. The program must assure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results. The DUR program will be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The DUR will be comprised of three sections: 1) Prospective DUR, 2) Retrospective DUR, and 3) An Educational Program.

The Contractor is required to comply with the SUPPORT for Patients and Communities Act, Title 1, Section 1004 (2018), as codified in Sections 1902 [ssa.gov] and 1932 [ssa.gov] of the Social Security Act, which mandates the following

- Contractor must have automated drug utilization review safety edits for opioid refills
- Automated claims review process to identify refills in excess of State limits
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics)
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

The DUR program will provide for various reports to be submitted to EOHHS in a specified format, to include:

- Data that is necessary for EOHHS to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than forty-five (45) calendar days after the end of each quarterly rebate period, pursuant to 42 CFR 438.3(s)(2). Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

- In accordance with 42 C.F.R. §438.3(s)(5), the Contractor will establish procedures to clearly identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from these reports to enable EOHHS to accurately bill for the rebate.
- A detailed description of its drug utilization review program activities to EOHHS on an annual basis.

In accordance with 42 C.F.R. §438.3(s)(6) and Section 1927(d)(5) of the Social Security Act, the Contractor must respond to requests for prior authorization for a covered outpatient drug by telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy-two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation.

Contractor is required to comply with RI General Assembly H-8313 Relating to Food and Drugs – Naloxone Access (2) Ensuring that opioid antagonists that are distributed in a non-pharmacy setting are eligible for reimbursement from any health insurance carrier, as defined under chapters 18, 19, 20, and 41 of title 27, and the Rhode Island medical assistance program, as defined under chapter 7.2 of title 42.

2.12.03.03 Quality Assurance

The Contractor agrees to have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas including all subcontractors. Emphasis will be placed on, but need not be limited to, clinical areas relating to management of chronic diseases, mental health and substance use care, members with special needs. The quality plan will ensure that eligible Medicaid beneficiaries are provided services that are accessible, of high quality, and promote positive health outcomes in a cost efficient and effect manner. The Contractor is required to include HEDIS measures in its quality plan that support the EOHHS Comprehensive Quality Strategy, and align with the RI Aligned Measure Set and the CMS Core Measures.

The Contractor's quality assurance/quality management plan will focus on clinical and nonclinical areas and involve the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of interventions
- Planning and initiation of activities for increasing or sustaining improvement

The Contractor agrees to report the status and results of each project to EOHHS, or its designees,

as requested, but at least within thirty (30) days following presentation to the Contractor's Quality Improvement Committee. The Contractor agrees to cooperate fully with EOHHS or its designees in any efforts to validate performance improvement projects. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The Contractor agrees to support joint quality improvement projects involving Health Plans and EOHHS. Contractor will be required to attend monthly Oversight meetings with EOHHS staff to review contract performance, compliance, quality assurance, continuous quality improvement. As part of EOHHS' strategic efforts to move from reactive contract performance evaluation to active contracting monitoring and oversight, EOHHS has aligned vendor management efforts towards Active Contract Management (ACM) to meet the Managed Care Goals.

The Contractor agrees to provide Medicaid HEDIS® and CAHPS® results to EOHHS, or its designees, within thirty (30) days, following presentation to the Contractor's Quality Improvement Committee.

The Contractor must contract with a state-approved vendor to ensure the appropriate and timely exchange of clinical data related to their quality performance i.e. HEDIS®.

For members under this Agreement, the Contractor will have defined protocols that require routine reporting on the quality of care outcomes, utilization patterns, and access to services (e.g., access barrier analysis).

The Quality Assurance Plan also will:

- Be developed and implemented by professionals with adequate and appropriate experience in QA
- Detect both underutilization and overutilization of services
- Assess the quality and appropriateness of care furnished to enrollees
- Provide for systematic data collection of performance and member results
- Provide for interpretation of this data to practitioners
- Provide for making needed changes when problems are found
- The Contractor will provide EOHHS with their Quality Assurance Plan for review and approval annually before finalization by the health plan.

2.12.03.04 Confidentiality

The Contractor must have written policies and procedures for maintaining the confidentiality of

data; including medical records/client information and STI appointment records that conform to HIPAA requirements. The Contractor will have available in its network providers willing to provide confidential family planning and STI services to adolescents.

2.12.03.05 State and Federal Reviews

The Contractor agrees to make available to EOHHS and/or its designees on an as needed basis, medical and other records for review of quality of care and access issues.

CMS and/or EOHHS may designate an outside review agency to conduct an evaluation of the Rhode Island Medicaid managed care program and its progress toward achieving program goals. The Contractor agrees to make available to CMS and/or EOHHS's outside review agency medical and other records for review as requested.

2.12.03.06 Practice Guidelines

The Contractor will develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236[xxii] 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 will 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.

2.12.03.07 Service Provision

The Contractor will provide services in the amount, duration, and scope of service in a manner that is expected to achieve the purpose for which the services were provided. The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. The Contractor will provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR 440.230 and for enrollees under the age of 21, as set forth in 42 CFR 438.210. The Contractor is prohibited from conditioning provisions of care or otherwise discriminating against a member based on whether the member has executed, or not executed, an advance directive.

2.12.04 Care Transitions

The Contractor will require participating network hospitals to measure and self-report to the Contractor, in a format and on a schedule determined by the Contractor, and approved by EOHHS, its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care provider

(PCP) about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit.

2.12.05 Provider Credentialing

EOHHS, through its contracts with the Contractor will ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements. This provision does not require the network provider to render services to FFS beneficiaries. This screening is to include provider assignment to a risk level to determine the scope of screening activity, verification of provider licensure, criminal background checks, site visits, federal database checks, and review of disclosures. EOHHS will work with the Contractor to develop a process to provide key information to the State agency to conduct the screening and to facilitate the collection of provider disclosures directly from the providers in accordance with 42 CFR 455.104-106.

The Contractor may execute the network provider agreement pending the outcome of the enrollment process for up to one-hundred and twenty (120) days but must terminate the provider from its network immediately upon notification from the State that the network provider cannot be enrolled or the expiration of one one-hundred and twenty (120) day period without enrollment of the provider. The Contractor agrees to have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State, or the state in which the covered service is furnished and are qualified to perform their services. The Contractor also will have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out of compliance with the Contractor's medical management standards.

The Contractor agrees that it will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor agrees not to employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

The Contractor must promptly notify EOHHS in writing of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality. The Contractor is required to report providers who are denied participation via the MCO Program Integrity Quarterly Report.

The Contractor must also promptly notify EOHHS in writing of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or

quality. This includes, but is not limited to, suspension actions and settlement agreements.

The Contractor will have a uniform credentialing and re-credentialing process and comply with that process consistently with State regulations and current NCQA "Standards and Guidelines for Accreditation of Health Plans". For organizational providers including nursing facilities, hospitals, and Medicare certified home health agencies, the Contractor must adopt a uniform credentialing and re-credentialing process and comply with that process consistent with State regulations. Personal Care Provider Agencies (PCPAs) are exempt from this requirement.

2.13 OPERATIONAL DATA REPORTING

2.13.01 General

The Contractor will comply with all of the reporting requirements established by EOHHS as documented in *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance*. EOHHS will provide the Contactor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports upon formal notification to Contractor. If the Contractor delegates responsibility to a subcontractor, the Contractor will ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. All reports listed in the Reporting Calendar are considered final and Contractor is responsible for submitting reports per the deadline in the Reporting Calendar on the date it is due.

EOHHS may, at its discretion, require the Contractor to submit additional reports both ad-hoc and reoccurring. If EOHHS requests any revisions to the reports already submitted, the Contractor will make the changes and re-submit the reports, according to the time frame and format required by EOHHS.

The Contractor will submit all reports to EOHHS utilizing the official EOHHS templates, unless otherwise not indicated in the Reporting Calendar, reports must be submitted to EOHHS using the schedule below:

Deliverables		Due Date
Daily Reports		Within two (2) business days
Weekly Reports		Wednesday of the following week
Bi-Weekly Reports		5th and 20th of each month
Monthly Reports		Last business day of the following month
Quarterly Reports		Last business day of the month following the end of the quarter
Semi-annual Reports		January 31 and July 31
Annual Reports		As specified by the State
Ad Hoc/On Demand		As specified by the State

Except as otherwise specified by EOHHS, all reports will include all Lines of Business governed by this contract.

The Contactor will transmit to and receive from EOHHS or its designee, all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by EOHHS, so long as EOHHS direction does not conflict with the law.

As part of its QM/QI program, the Contractor will review all reports and data submitted to EOHHS to identify any instances and/or patterns of such non-compliance, including missing/incorrect information, and quality improvement activities to identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and improve performance.

In accordance with the requirements set forth in 42 U.S.C. §300kk, the Contractor must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language and disability status for members and from members parents or legal guardians if member are minors or legally incapacitated individuals. In collecting this data, the Contractor will use the Office of Management and Budget (OMB) standards, at a minimum, for race and ethnicity measures.

The Contractor agrees to provide EOHHS with uniform utilization, quality assurance, and Member satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to EOHHS. Record content must be consistent with the utilization control requirement of 42 CFR 456.111[xxiii]. The utilization review plan must provide that each Member's record includes information needed for the Utilization Review Committee to perform required utilization review activities. The Contractor also agrees to cooperate with EOHHS in carrying out data validation activities.

2.13.02 Encounter Data Reporting

2.13.02.01 Definitions

(1) Encounter Data: The record of a member receiving any item(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other risk basis payment methodology.

(2) Accurate Claims: All fields reflect the service provided and paid and are completed per the data submission guideline and State's companion guide.

(3) Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection.

2.13.02.02 General Requirements

Pursuant to 42 CFR 438.242(c), the Contractor will submit to EOHHS complete, accurate, and timely encounter data for all services for which the Contractor has incurred any financial liability,

whether directly or through subcontracts or other arrangement. The Contractor will submit encounter data monthly and in compliance with the EOHHS guidance document *"Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance"*. EOHHS reserves the right to make changes to the guidance document at any time. The Contractor is expected to implement all changes within ninety (90) calendar days of notification. The Contractor is solely responsible for submitting all subcontractor encounter data in compliance with EOHHS' encounter data requirements.

2.13.02.03 Timeliness and Accuracy of Data Submittal and Correction of Rejected Claims

The Contractor is responsible for collecting, monitoring, submitting and ensuring the accuracy of all 837 submissions and subsequent 277CA reports. The Contractor will submit complete, accurate, and timely encounter data for all services that it, or its subcontractors, have incurred a financial liability within thirty (30) business days of the end of the month in which the liability was incurred. The Contractor will ensure that ninety-eight percent (98%) of submitted encounters are accepted and do not reject, upon initial submission.

Submitted encounters and encounter records must pass all the EOHHS designated Medicaid Management Information System ("MMIS") edits. Submitted encounters or encounter records must not be duplicates of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

The Contractor is responsible for re-submitting any errored off/rejected claims to the State within thirty (30) business days of the receipt of the rejection and/or applicable rejection report, such as 277CA reports. The Contractor is subject to corrective action and/or financial penalties for non-submitted, late, or persistently rejected/incorrect data submissions.

2.13.02.04 Data Validation

The Contractor agrees to reconcile encounter data, including that of its subcontractors, and to attest to its accuracy with each submission. The Contractor agrees to assist EOHHS in its validation of utilization data by making available a sample of medical records and a sample of its claims data upon request.
The Contractor will submit monthly reports that summarize file submission status by vendor, line of business and fiscal year in a format determined by EOHHS. The report will include, at a minimum:

1. Encounter Claims Incurred (total volume and dollars)
2. Encounter Claims Submitted (total volume and dollars)
3. Encounter Claims Accepted (total volume and dollars)
4. Number of claims and dollar value by error type (total volume and dollars)

The Contractor will submit documentation and explanation with these reports if the denial rate is

greater than two percent (2%) between and among the total value for categories 1-3 above for data outside of timely submission or correction timeframes described herein.

Contractor is responsible to reconcile Financial Data Cost Report (FDCR) cost allocations and the File Submission Report (FSR), which contains the encounter data reporting outlined above. The reported Incurred Expenditures submitted in the File Submission Report must align with the sum of the Direct Paid, Non-State Plan Paid, and Subcapitated Proxy Paid expenditures submitted in the Financial Data Cost Report for each state fiscal year within the point one percent (.1%) threshold. The FSR and FDCR used for this comparison will include the same paid run-out period. Failure to meet threshold will result in financial penalty and/or corrective action by EOHHS as outlined in "*Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance*."

2.13.02.05 Participation in Encounter Data Meetings

The Contractor must participate in regular meetings with the State relating to the 837 processing and must submit reports to the State on 837 processing, at a frequency defined by the State. Topics addressed at meetings include, but are not limited to, review of the file submission reports, documentation of variances, and comparisons of accepted claims as reflected in the MMIS to incurred claims as reflected on payer-supplied submission reports.

2.13.02.06 Penalties for Non-Compliance

At the discretion of EOHHS, the Contractor may be subject to monetary penalties if the encounter denial rate exceeds two percent (2%). EOHHS may assess the following penalties:

- Civil monetary penalties in the amount of one-hundred thousand dollars ($100,000), not to exceed one-percent (1%) of the Contractor's capitation, to be assessed each month that the Contractor submits encounters, including the encounters of their subcontractor, for which the denial rate exceeds two percent (2%).
- Appointment of temporary management for the Contractor as specified 42 CFR 438.706.
- Granting members, the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of new enrollment, including default enrollment, after notice of the effective date of the sanction.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

2.13.03 Grievance and Appeals Data

The Contractor agrees to submit reports in the appropriate format and timetables identified by EOHHS within this contract and as specified in Reporting Calendar. The Contractor agrees to submit quarterly reporting for Complaints, Grievance and Appeals submitted to the Plan. Reports will be inclusive of all Lines of Business identified in this contract.

In accordance with 42 C.F.R. §438.416, the Contractor will provide the following with each record of a grievance or appeal:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution information for each level of the appeal or grievance, if applicable;
- The date of resolution at each level, if applicable; and
- The name of the covered person for whom the appeal or grievance was filed.

2.13.04 EOHHS Quality Assurance Data

The Contractor agrees to make available internal quality assurance reports periodically to EOHHS, as EOHHS may specify. The Contractor also agrees to perform medical record abstracts in selected quality assurance areas, at a minimum of four (4) such areas for RIte Care including one directed at Children with Special Health Care Needs, one (1) such area for Rhody Health Partners Members and, in any contract year, to be specified by EOHHS, for use in external quality review. The precise methodology for these abstracts will be provided to the Contractor by EOHHS. The Contractor agrees to work cooperatively with EOHHS in developing and implementing this methodology.

The Contractor will provide the results of any quality improvement studies/projects and Medicaid HEDIS® and CAHPS® results within thirty (30) days of their presentation to the Contractor's Quality Improvement Committee.

2.13.05 Member Satisfaction Report

The Contractor agrees to collect Member satisfaction data for all lines of business through an annual survey of a representative sample of its Members.

2.13.06 Provider Satisfaction Report

The Contractor agrees to collect provider satisfaction data for all lines of business through an annual survey of a representative sample of the Contractor's providers.

2.13.07 Fraud and Abuse Reports

The Contractor agrees to submit a quarterly fraud and abuse report that conforms to EOHHS's specifications. This report is due no later than thirty (30) days after the end of the reporting quarter. Official due date is listed in the Reporting Calendar for the Contractor. The Contractor will also submit a listing of all practitioners who have been removed from the Contractor's network, either for cause or at the request of the practitioner. This list will be attached to the quarterly fraud and abuse report. The Contractor will recognize that this listing will not replace the requirement that the Contractor report, in writing, any actions taken to terminate or suspend a practitioner from the Contractor's network due to quality, Medicaid fraud or abuse, or integrity, within ten (10) calendar days of the practitioner's identification.

As indicated in 42 CFR 455.17 the report will indicate at minimum: (1) the number of complaints of fraud and abuse that warranted preliminary investigation, and (2) for each case of suspected provider fraud and abuse that warrants a full investigation. For the latter case, the Contractor will report the following:

- the provider's name and number
- the source of the complaint
- the type of provider
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred

2.13.07.01 Member Fraud and Out of State Report

The Contractor will provide monthly reports on any out of state pharmacy activity in specified reporting template as described in Reporting Calendar.

In the case of members utilizing an out of state pharmacy, EOHHS requires the Contractor to do research necessary to establish a pattern that is suggestive of out of state residency. An example includes learning that a member has picked up maintenance medications at an out of state pharmacy for three (3) or more consecutive months.

Contractor to reporting addresses changes, including members who report out of state address changes, to EOHHS by policy and procedure outlined in *EOHHS Medicaid Managed Care*

Organization (MCO) Requirements for Medicaid Member Demographic Changes.

2.13.08 RIte Share Reporting

If the Contractor has an active non-Medicaid product, the Contractor will provide claims-based data to EOHHS for any RIte Share Member enrolled and identified by EOHHS; provided however that nothing in this Section nor in any other provision of this Agreement will be interpreted to require the Contractor to participate in RIte Share.

2.13.08.01 Recovery Reporting

In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.

2.13.09 Presentation of Findings

The Contractor agrees to obtain EOHHS's approval prior to publishing or making formal public presentations of statistical or analytical material based on its Member enrollment.

2.13.10 Health Insurance Portability and Accountability Act Requirements (HIPAA)

The Contractor will comply with the operational and information system requirements of HIPAA, including issuance of applicable certificates of credible coverage when coverage is terminated, and will report requested data to EOHHS or its designee.

2.13.11 Certification of Data

The Contractor agrees to certify data in accordance with 42 C.F.R. § 438.606. . The certification must attest, based on best knowledge, information, and belief, as follows:

- To the accuracy, completeness and truthfulness of the data.
- To the accuracy, completeness and truthfulness of the documents specified by the State.

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

Certification of data policy and procedures are outlined in *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance.*

2.13.12 Patient Protection and Affordable Care Act

The Contractor will comply with all compliance standards and operating rules of the Patient Protection and Affordability Care Act (PPACA) and will report data as requested by EOHHS or its designee on a timely basis.

The Contractor will provide EOHHS with quarterly pharmacy claims information with respect to Drug Rebate Equalization (DRE) in a format that is compliant with CMS published guidelines and approved by EOHHS.

2.13.13 All Payer Claims Database

The Rhode Island All Payer Claims Database (RI-APCD), is a repository of healthcare insurance payment information for people living in Rhode Island. The data will come from the major health insurance companies doing business in Rhode Island, including fully-insured and self-funded commercial plans, Medicare and Medicaid. The development Rhode Island All Payer Claims Database is a collaborative effort amongst the Rhode Island Department of Health, the Office of the Health Insurance Commissioner, the Health Benefits Exchanges, and the Executive Office of Health and Human Services. Pursuant to RI General Law Section 23-17.17-10, the Contractor will submit timely data exchange files to the All Payer Claims Database (APCD), according to the schedule that is established by the RI-APCD.

2.14 GRIEVANCE AND APPEALS

2.14.01 General

EOHHS has established a Grievances and Appeals function through which members can seek redress against Health Plans, and through which Health Plans can seek to disenroll members who are habitually non-compliant or who pose a threat to Health Plan employees or other members. The grievance system includes a grievance process, an appeals process, an external appeal (medical review) process and access to the State's Fair Hearing system. For its part, the Contractor will have written policies and procedures conforming to 42 C.F.R. Part 438, Subpart F and the EOHHS requirements for resolving member complaints and for processing grievances, when requested by the member or when the time allotted for complaint resolution expires. Such procedures will not be applicable to any disputes that may arise between the Contractor and provider regarding the terms, conditions, termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers.

The Contractor is required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

In accordance with 42 C.F.R. §438.416, the record of each grievance shall contain, at a minimum, all the following information:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the covered person for whom the grievance or appeal was filed.

The record must be accurately maintained in a manner accessible to the state and available, upon request, to CMS.

2.14.02 Adverse Benefit Determination

In accordance with 42 C.F.R. §438.404, a notice of Adverse Benefit Determination as defined of Section 1.06 of this Agreement, must be in writing and must explain:

- The action that the Contractor, or its agents, has taken or intends to take.
- The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The member's or provider's right to file an appeal with the Contractor, including information on exhausting the Contractor's one level of appeal, the right to an external appeal (medical review), and the right to request a State Fair Hearing.
- The procedures for exercising the rights in this section.
- The circumstances under which expedited appeal resolution is available and how to request it.
- The member's rights to have covered benefits continue pending resolution of the appeal and the final decision of EOHHS. How to request that benefits be continued and the

circumstances, consistent with state policy, under which the members may be required to pay the costs of these services.

The Contractor may mail notice of adverse benefit determination on the date of the action when:

- The Contractor has factual information confirming the death of the member;
- The member submits a signed written statement requesting service termination;
- The member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result;
- The member has been admitted to an institution where he or she is ineligible under the plan for further services;
- The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
- A change in the level of medical care is prescribed by the member's physician;
- The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act; or
- The transfer or discharge from a facility will occur in an expedited fashion.

The Contractor must notify requesting providers and give members written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less that the requested authorization. The Contractor must give members timely and adequate notice of an adverse benefit determination in writing as expeditiously as the member's condition requires and consistent with timeframes pursuant to 42 C.F.R. §438.404(c). Contractor may extend the adverse benefit determination timeframe for standard authorization decisions that deny or limit services for up to fourteen (14) additional calendar days if either the member or the provider request the extension, or the Contractor justifies a need for additional information and shows that the extension is in the member's best interest. For prior authorizations for outpatient drugs, the Contractor must respond to requests by telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy-two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation.

If the Contractor has facts indicating that an adverse benefits determination should be made because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources, the Contractor may mail the notice of adverse benefit determination as few as five (5) days prior to the date of action. The Contractor shall provide a notice of adverse determination on the date of the determination when the action is a denial of payment.

The Contractor will also meet the requirements in 42 CFR 438.10 regarding information provided to enrollees. Written materials must use easily understood language and enrollees must be

informed that alternative formats are available for those with special needs including those who are visually impaired or have limited reading proficiency. All written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information per 42 CFR 438.71 (a).

2.14.03 Health Plan Grievance and Appeals Process

The Contractor's policies and procedures for processing grievances must permit a member, provider or authorized representative, acting on behalf of the member and with the member's written consent, to file a grievance with the Contractor at any time. The timeframe for resolution is ninety (90) calendar days from receipt of the grievance as provided in Rhode Island Medicaid Managed Care Grievance and Appeals Process.

The Contractor's policies and procedures for processing appeals must permit a member, provider or authorized representative acting on behalf of the member and with the member's written consent, to file an appeal of a notice of adverse benefit determination within sixty (60) calendar days from the date on the Contractor's notice.

In handling grievances and appeals, the Contractor must:

- Give members any reasonable assistance in completing forms and taking procedural steps, including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Allow members to file grievance or appeal verbally which must be confirmed in writing to establish the earliest possible filing date unless there is a request for an expedited appeal.
- Provide members with an acknowledgment of receipt of each grievance and appeal within five (5) calendar days.
- Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making and they are not subordinates of any such individual.
- Ensure that decision makers on grievance and appeals are health care professionals who have appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if they are involved in deciding on any of the following: (a) an appeal of a denial that is based on lack of medical necessity, (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal that involves clinical issues
- Ensure that that decision makers on grievances and appeals consider all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

- Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Provide the member and his or her representative the member case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor considered during the appeals process. The Contractor will provide this information to the member free of charge and sufficiently in advance of the resolution timeframes for the appeals as specified in 42 CFR 438.408 (b) and (c). Under certain circumstances, certain categories of medical records and other documents may not be available to the member based on the type of record including, but not limited to, mental health records; and (d) include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate.

The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires but not to exceed ninety (90) calendar days from the date that the Contractor received the grievance. For resolution of each standard appeal, the Contractor must provide written notice of the disposition within thirty (30) calendar days from the time the Contractor receives the appeal. The timeframes for both grievances and appeals resolution may be extended by up to fourteen (14) calendar days if the member requests an extension or if the Contractor shows (to the satisfaction of EOHHS upon request) that there is need for additional information and how the delay is in the member's best interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;
- Within two (2) calendar days, give members written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Each written notice of determination must include the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members, the right to a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

2.14.04 Expedited Resolution of Appeals

The Contractor must also establish and maintain an expedited review process for appeals. An expedited review is permitted when the Contractor determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited appeals must be resolved within seventy-two (72) hours of receipt of the appeal. The member may submit a verbal request for an expedited resolution of appeal. The member does not need to follow an oral request for an expedited resolution of appeal with a written request. The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

The Contractor may extend the timeframe for an expedited appeal by fourteen (14) days if the member, the member's representative or the provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the member's interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;
- Within two (2) calendar days give the member's written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

The Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's request.

If the Contractor denies the request for an expedited appeal, it must transfer the appeal to the timeframe for standard resolution, make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

Each written notice of determination must include the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members, the right to a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

2.14.05 Continuation of Benefits

As specified in 42 CFR 438.420, the Contractor must continue the member's benefits while an appeal is in process if all the following conditions are met:

- The member files a timely request for an appeal;
- The member files for a continuation of benefits before the later of ten days of the Contractor mailing the notice of adverse benefit determination, or the intended effective date of the Contractor's proposed action;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- The authorization period has not expired.

If the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal or requests a state fair hearing;
- The member fails to request a State Fair Hearing and a continuation of benefits within ten (10) calendar days after the Contractor sends the notice of an adverse resolution
- A State Fair Hearing decision is adverse to the member.

2.14.06 State Fair Hearing and External Appeal (Medical Review Process)

If the member has exhausted the Contractor's internal appeals procedures and the Contractor upholds the adverse benefit determination, the member, or a provider or representative acting on the member's behalf, may request a State Fair Hearing. The State must grant the request for a State Fair Hearing if the member submits the request within one hundred and twenty (120) calendar days of the Contractor's notice of resolution. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member by the Contractor.

For members who have exhausted the Contractor's internal appeals procedures and the Contractor has upheld the adverse benefit determination, the State also offers and arranges for an external medical review if the following conditions are met:

- The review must be at the member's option and must not be required before or used as a deterrent to proceed to the State fair hearing;
- The review must be independent of both EOHHS and the Contractor;
- The review must be offered at no cost to the member;
- The review must not extend any of the timeframes specified in the contract and must not disrupt the continuation of benefits.

The member must submit a request for an External Appeals (Medical Review) within four (4) months of the Contractor's notice of resolution. The External Appeal (Medical Review) is governed by the Office of the Health Insurance Commissioner (OHIC) under the external appeal procedural requirements pursuant to RIGL 27-18.9-8 of the Benefit Determination and Utilization Review Act and is a level of review which is aside and apart from the State Fair Hearing process. The Member may request either a State Fair Hearing or an External Review or, if desired, both. The External Appeal (Medical Review) can occur simultaneously or consecutively with the State Fair Hearing as long as the request is made within four (4) months of the Contractor's notice of final resolution. The Contractor will execute individual contracts with each OHIC identified Independent Review Organizations (IRO) to permit Medicaid members access to an External Appeal (Medical Review). The Contractor will use the rotational IRO registry system specified by the OHIC Commissioner. The Contractor agrees to submit appeals related reports to both EOHHS and OHIC in a format and template approved by both State Agencies. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination and appeal resolution, The Contractor may recover the cost of the services furnished the member while the appeal was pending, to the extent that they were furnished solely because of the requirements of 42 CFR 438.420, and in accordance with the policy set forth in 42 CFR 431.230(b).

If the Contractor, State Fair Hearing officer or external reviewer reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

State ensures that any member dissatisfied with a State agency determination denying a member's request to transfer plans/disenroll is given access to a State Fair Hearing.

2.15 PAYMENTS TO AND FROM PLANS

2.15.01 Acceptance of State Capitation Payments

The Contractor will be capitated for all in-plan services, as described in Section 2.06 in the amount specified in ATTACHMENT J, and such reimbursement will be subject to all conditions specified

in this Agreement. ATTACHMENT L describes the rate-setting process used and the basis for establishing the rates in ATTACHMENT J.

The monthly capitation rates set forth in ATTACHMENT J will not be subject to change during the effective period therein specified except: (1) by Federal or State law; or (2) to cover additional services not currently included in ATTACHMENT A or to reflect a reduction in covered services; or (3) unless such change has been negotiated in accordance with Section 3.03 of the Agreement. Such change in rates will not be effective until agreed in writing by the parties or, in the event of a change due to (1) above, until written notice by EOHHS to the Contractor.

EOHHS will make Capitation Payments to the Contractor on a monthly basis via electronic funds transfer in the following manner:

- For RIte Care members EOHHS will not pay a SOBRA payment for miscarriages (defined as spontaneous fetal death less than twenty (20) weeks), nor will EOHHS make a SOBRA payment for a pregnancy resulting in induced termination regardless of gestational age.

- For RIte Care and Children with Special Health Care Needs members, on or before the fifth (5th) business day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Health Plan for the present month, as of a date on or about the twenty-fifth (25th) of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during the present month.

- Along with the amount identified in the above paragraph, adjustment will be made for members for whom an enrollment or disenrollment transaction was made after the 25th day of the next previous month but before the close of the month in question. The adjustment will be based on a daily rate equal to 1/30th of the month rate for each age/sex rate category (rounded to 1/10th of a cent, e.g., $3.873). A remittance advice will accompany all payments identifying every member, their Medicaid ID number, the number of days paid and total payment and/or adjustments.

- For members whose enrollment lapses for any portion of a month in which a capitation payment was made, due to loss of eligibility, death or other circumstance, EOHHS will adjust its next monthly Capitation Payment to recoup the portion of the capitation payment to which it is due to a refund.

- For Rhody Health Partners members, on or before the last day of every month, the Contractor will receive a roster of individuals projected to be enrolled in or assigned to the Contractor for the following month.

- For Rhody Health Partners members, on or before the fifth (5th) calendar day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for

services rendered to these individuals during that month.

- For RIte Care members who are pregnant and whose pregnancy results in a live birth or still birth (still birth defined as spontaneous fetal death at greater than or equal to 20 weeks gestation), EOHHS will make a supplemental (SOBRA) payment for delivery as part of its monthly capitation payment on the basis of a valid claim by the Contractor.

- For members with a cost-sharing requirement to the Contractor, the amount of the capitation will be reduced by the portion of the premium, or copayment, which is the responsibility of the member.

The Contractor agrees to accept enrollment information and capitation payments in this manner and will have written policies and procedures for receiving and processing capitation payments.

For RIte Care members on or before the fifth (5th) calendar day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during that month.

General Capitation Payments, as defined in Section 1.7, may only be made by the State and retained by the Contractor for managed care members eligible for Covered Services, in accordance with 42 CFR 438.3(c)(2).

In accordance with 42 CFR 438.3(c)(1)(i) Standard Contract Requirements concerning payments. The following requirements apply to the final capitation rate and the receipt of capitation payments under the contract: (1) The final capitation rate for each MCO, PIHP or PAHP must be specifically identified in the applicable contract submitted for CMS review and approval.

In accordance with 42 CFR 438.3(e)(1)(ii) the Contractor agrees that they shall cover for enrollees, services that are in addition to those covered under the State plan. Specifically, the Contractor agrees to cover such additional services that are necessary to comply with 42 CFR 438.910.

In accordance with 42 CFR 457.1201(c),(n)(2),(o),(p) Contractor agrees that State shall make the final capitation rates and payment in accordance with 42 CFR 438.3(c), 457.1207(o), 457.1240(b) (cross-referencing 42 CFR 438.330(b)(2), (b)(3), (c), and (e)) 457.1240(e) (cross-referencing 42 CFR 438.340) and 457.1250(a) (cross-referencing 42 CFR 438.350).

2.15.01.01 Fee Schedule Increase, Adoption of Minimum/Maximum Fee Schedule and State Directed Payment Requirements

EOHHS may require the MCO to adopt a minimum fee schedule for network providers, provide a uniform dollar or percentage increase for network providers or adopt a max fee schedule so long as MCO retains ability to reasonably manage risk.

42 CFR § 438.6(c) sets forth criteria to receive written approval prior to implementation the arrangement shall be developed as outlined there by submitting a "preprint" to CMS. Per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Rates for Nursing Facilities, Inpatient Hospitals, and Outpatient Hospital are set annually based on Rhode Island General Law.

MCOs must comply with the following State directed payments:

Pre-Print Description	Pre-Print Payment Requirement	Effective Date
Hospital Inpatient and Outpatient Rates	2.4% increase over prior year rates	7/1/2021
Nursing Home Rates	2.2% increase over prior year rates	10/1/2021
PCMH PMPM	$3.00 PMPM for each member attributed to providers that meet the OHIC definition of PCMH as stated here.	7/1/2021
PCMH quality incentive	$0.50 PMPM incentive for each member attributed to providers that meet quality targets on clinical target measures outlined here.	7/1/2021
CTC payment	$1.15 PMPM paid to the Care Transformation Collaborative for administration of the program, for each member attributed to providers that meet the OHIC definition of PCMH. Administration includes such activities as: practice facilitation, technical assistance, coaching, and learning collaboratives to support practices in achieving the necessary requirements to become NCQA and OHIC recognized as a PCMH upon completion of the program.	7/1/2021
Level IV Detox	$1,617.00 per diem	7/1/2021

- **Increase to Pediatricians Rates to ensure access to care:**

  In order to ensure adequate access to primary care for children, EOHHS requires that a minimum fee schedule for participating pediatricians be set at seventy-five percent (75%) of RI Medicare rates for all E&M codes. This increase must be implemented and maintained for the duration of this agreement by the Contractor effective June 1, 2017.

2.15.01.02 Incentive Payments

As part of CFR 42 CFR 438.6, the State has the authority to implement incentive payments to providers. All incentive payments will be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy. Incentive payments are available to both public and private contractors under the same terms of performance. Through this contract the State is implementing certain incentive programs, payments for which will be made directly by Rhode Island Medicaid to the Medicaid MCO based upon EOHHS approval of such arrangements and EOHHS determination of satisfactory compliance with such incentive arrangements. These Incentive Programs include:

- **Rhode Island's Health System Transformation Program**

  CMS has approved amendments to Rhode Island's 1115 Demonstration Waiver enabling EOHHS to proceed with its Health System Transformation Project. Contracted Medicaid MCOs are anticipated to be full partners in HSTP to support and incentivize a critical transformation of RI's system of care. There are two specific incentive related components to this program: (a) the Hospital and Nursing Home Incentive program and (b) the HSTP related Medicaid Incentive Infrastructure Program.

  These incentive payments are not to be considered part of the medical component of the premium payment made to the Health Plan and will not be included in any risk/gain share calculations between EOHHS and the Contractor. Neither the MCO-IMP incentive payment to the Contractor by EOHHS nor the AEIP incentive payments made by the Contractor to AEs will be included in any risk/gain share calculations or in any total cost of care calculations pertaining to arrangements with AEs. Total incentive payment inclusive of performance goal and/other provider performance-based payments cannot exceed five percent of capitation.

- **Hospital and Nursing Home Incentive Program**

  Note that this contract pertains to the Hospital Incentive program only. EOHHS will address the Nursing Home portion of the Incentive program elsewhere.

  To implement the Hospital Incentive portion of HSTP, EOHHS developed and implemented the Hospital Incentive program, inclusive of data collection, performance measurement and scoring, dollar allocation for payment to providers, and funds distribution. The program included one-time payments made to hospitals by contracted MCOs with total payments not exceeding $13.5 million and with all payments to be made on or before December 31, 2017.

  EOHHS has provided the Contractor with specific provider performance reports that details each specific hospital, the performance measure, baseline for each measure, identified benchmark, performance score, and dollars allocated for each measure.

In advance of the Contractor's payments to hospitals, the Contractor received payment from EOHHS in the amount and schedule set forth stipulated in the provider performance report. The Contractor used this report to make the incentive payment to each applicable hospital on a scheduled basis as determined by EOHHS.

The total amount to be paid for each provider will be equally distributed among each contracted Health Plan. Payments to the applicable hospitals as specified in the provider performance report are based on demonstrated achievement of pre-determined performance benchmarks for established measures; if a hospital does not achieve the benchmark, no payment will be made.

- **Medicaid Infrastructure Incentive Program**

  A central feature of the Health Systems Transformation Program is the advancement of Accountable Entities through contractual partnerships with MCOs participating in the Medicaid managed care program. Such partnerships must comply with the provisions set forth in Section 2.08.02 ("Contracting with EOHHS Certified Accountable Entities") of this Agreement.), inclusive of Sections 2.08.02.01 through 2.08.02.06 which specifically address the terms and conditions for HSTP based incentive arrangements between the Contractor and AEs and between EOHHS and the Contractor.

2.15.01.03 General

EOHHS believes that one of the advantages of a managed care system is that it permits Health Plans and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. However, the Contractor agrees to make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. To ensure access and quality of care for its members to behavioral health services, the Contractor agrees to make timely and accurate payments to its behavioral health providers. The Contractor also agrees to abide by the special reimbursement provisions for FQHCs and RHCs described below.

The Contractor will include language in all provider contracts to encourage provider enrollment as a user of Current Care, including hospital alerts. The Contractor will cooperate with the state-designated Regional Health Information Organization in engaging provider participation in Direct Messaging services to improve care coordination. The Contractor will include language that requires providers to encourage and assist their high utilizing patients to enroll in Current Care. High utilizers are defined by the Contractor and approved by EOHHS. The Contractor will include this language in all primary care and specialty provider contracts as they become eligible for renewal.

Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers).

2.15.01.04 Retroactive Eligibility Period

The Contractor will not be responsible for any payments owed to providers for services that were rendered prior to a member's enrollment, even if they fell within any applicable period of retroactive eligibility for Medicaid.

2.15.01.05 In-Network (Contracted) Services

The Contractor will be responsible for making timely payment and meet the requirements of 42 CFR 447.45[xviii] and 42 CFR 447.46[xxiv] for Medically Necessary, Covered Services rendered by in-network providers when:

- Services were Emergency Services
- Services were rendered under the terms of the Health Plan's contract with the provider
- Services were prior authorized

A claim means (1) a bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill. A clean claim means one that can be processed without additional information from the provider of service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. Timely payment means within thirty (30) days of receipt of a "clean claim" for reimbursement. Timely payment is judged by the date that the Contractor receives the claim as indicated by its date stamped on the claim and the date of payment is the date of the check or other form of payment.

Under these terms, the Contractor will not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of the Contractor's contract with the provider.

The Contractor will make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e)[xxv].

2.15.01.06 Out-of-Network and Out-of-State Providers

The Contractor will be responsible for making timely payments to out-of-network providers for Medically Necessary, covered services when:

- Services were Emergency Services
- Services were prior authorized

Under these terms, the Contractor will not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior

authorized or otherwise conformed to the terms of the Contractor's contract with the provider.

For services provided to eligible and enrolled members, claims for services from a provider may be paid at established Rhode Island Medicaid fees that are in effect at the time of service when the following two conditions are met, and the provider does not have an existing agreement with the Contractor:

a) The provider must be an out-of-State provider, and
b) The provider must be out-of-network

For services provided to members, claims from out-of-network providers may be paid at established Rhode Island Medicaid fee-for-service rates that are currently in effect at the time of service or at a fee negotiated between the Contractor and the provider of services.

Any provider of Emergency Services that does not have in effect a contract with the Contractor must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the enrollee received Medicaid other than through enrollment under this Agreement.

The Contractor will make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e)[xxv].

2.15.01.07 FQHCs/RHCs

If the Contractor includes FQHCs or RHCs in its network, it agrees to address cost issues related to the scope of services rendered by these providers and must reimburse them either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. The Contractor agrees to reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers.

2.15.01.08 Hospital Services

The Contractor will be required, to implement reforms required by Rhode Island State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) which stipulates certain requirements for payments to hospitals.

EOHHS recognizes that providing Long Acting Reversible Contraceptive Devices (LARCs) immediately post-partum in a hospital setting and prior to discharge has been shown to be effective in prolonging inter -birth intervals and preventing pre-term birth. The Contractor is required to reimburse providers for LARCs outside of the global fee for labor and delivery when the device is inserted post-partum in a hospital setting. The Contractor will reimburse separately for the LARC, outside of the global fee for labor and delivery.

The Contractor will provide quarterly reporting regarding payments as stipulated by R.I. General

Law Chapter 40-8, Section 40-8-13.4.

2.15.01.09 Nursing Homes

The Contractor will negotiate the reimbursement rates with nursing home providers. The Contractor will establish rates that consider the acuity of care provided to members as well as contain quality indicators. As a condition for payment, the Contractor must ensure that the Nursing Home has met all federal and state OBRA/PASRR requirements for all individuals seeking admission or readmission to a nursing home, subsequent to the provisions in 42 CFR 483.100-138 and Rhode Island Rules and Regulations for Medicaid Section 0378.05. EOHHS will approve the reimbursement method used to reimburse nursing facilities.

2.15.01.10 Liability During an Active Grievance or Appeal

The Contractor will not be liable to pay claims to providers if the validity of the claim is being challenged by the Contractor through a grievance or appeal unless the Contractor is obligated to pay the claim or a portion of the claim through its contract with the provider.

2.15.01.11 Limit on Payment to Other Providers

In accordance with 42 CFR 438.60[xxvi], no payment will be made for services furnished by a provider other than the Contractor or by one of the Contractor's participating providers, if the services were available under the contract.

2.15.01.12 Physician Incentive Plans

The Contractor will not place physicians at substantial financial risk for services which avoid costs by limiting referrals to specialty care or reduce medically necessary services to members. Also, the Contractor will not place physicians at substantial financial risk for services that are not provided by the physician or physician group. The Contractor will comply with Federal definitional, operational, and reporting requirements governing physician incentive plans as defined at 42 CFR 422.208[xxvii] and 42 CFR 422.210, 42 CFR 434.70 and 42 CFR 1003. In accordance with 42 C.F.R. §438.3(i).

2.15.01.13 Actuarial Basis

The actuarial basis in the rate setting process for the computation of capitated rates is provided in ATTACHMENT J of this Agreement.

2.15.01.14 Prohibition on Restocking and Double Billing of Prescription Drugs

To conform to Section 1903(i)(10) of the Social Security Act, 42 U.S.C. 1396b(i), payment will not be made with respect to any amount expended for reimbursement to a pharmacy for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than with respect to a reasonable restocking fee for such drug).

2.15.01.15 Payment Adjustment for Provider Preventable Conditions

The Contractor will meet the requirements of 42 CFR 447.26[xxviii], Subpart A[xxix], 42 CFR 434.6(a)(12), 42 CFR 438.3(g); 42 CFR 447.26(d) and sections 1902(a)(4), 1092(a)(6) , and 1903**Error! Bookmark not defined.**, with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions. Specifically, this includes the development of the capacity for claims systems to recognize and reject/deny procedures coded with the modifiers PA (surgical or other invasive procedure performed on the wrong body part), PB (surgical or other invasive procedure performed on the wrong patient), and PC (wrong surgical or invasive procedure performed on a patient). The disallowance of reimbursement for OPPCs applies to freestanding and hospital-based clinics, freestanding and hospital-based ambulatory surgery services, office-based settings and emergency departments that submit claims to the Contractor. The Contractor will require its contracted providers to identify and report provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to member for which Medicaid payment would otherwise be available. EOHHS will recoup all funds related to the inappropriate payment by the Contractor for provider preventable conditions, health acquired conditions and never events. EOHHS, at its discretion, will require Contractor to report claims paid to providers and facilities for provider preventable conditions and/or hospital acquired conditions.

2.15.01.16 Health Insurer Fee

If applicable, the Contractor may be subject to the Health Insurer Fee (HIF) under Section 9010 of the Patient Protection and Affordable Care Act of 2010. The HIF is imposed on qualifying health insurers based on their premiums in the previous year. If the Contractor is subject to the HIF, EOHHS will pay the Contractor's HIF retrospectively.

The amount due to the eligible Contractor shall be determined based on the Contractor's final Form 8963 filing, the final notification of the HIF amount owed by the Contractor received from the United States Internal Revenue Service, and any additional supporting documentation as requested by EOHHS. If Congress issues a moratorium for the HIF in any given year, EOHHS will not issue any payment to the Contractor. Payment is contingent on the availability of State funds.

2.15.02 Cost Sharing

Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50[xxx] through 42 CFR 447.56[xxxi].

EOHHS will have sole responsibility for determining the cost-sharing responsibilities for members. EOHHS will notify members of their cost-sharing responsibilities including the amounts of cost-sharing. EOHHS will notify the Contractor of a member's cost-sharing responsibilities, if applicable.

The Contractor will have policies, practices and procedures to ensure that cost-sharing responsibilities, if applicable, are met. Members are required to pay providers monthly of their cost-sharing responsibilities, if applicable.

2.15.02.01 General RIte Care Cost-Sharing

The RIte Care program has no cost-sharing requirements (premiums and copayments) for any member. In accordance with 42 CFR 438.106 , the Contractor agrees that RIte Care members are held harmless from fees, including the debts of the Contractor in the event of the Contractor's insolvency or the Contractor's failure to pay a health care provider or supplier of covered services or goods and will not bill or attempt to collect any other fee from RIte Care members.

2.15.02.02 Exemption for Indians Served by Indian Healthcare

The Contractor will exempt Indians from payment of enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through Contract Services, HIS (CHS). The Contractor must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

2.15.04 Third-Party Liability

Third-Party Liability ("TPL") refers to any individual entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of member's health coverage including subrogation. Under Section 1902(a) (25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

The Contractor agrees to take responsibility for identifying TPL for members and reporting such TPL source to EOHHS within five (5) calendar days of the source becoming known to the Contractor, in a format determined by EOHHS. The Contractor will collect and retain all Third-Party Liability collections.

The Contractor agrees to cooperate with EOHHS in the implementation of RI General Laws 40-6-9.1 by participating in the matching of data available to EOHHS and to the Contractor through an electronic file match. The matching of such data is critical to the integrity of the Medicaid program and the use of public funds. Requests made of the Contractor by EOHHS will be made at such intervals as deemed necessary by EOHHS to participate in the data matching. The Contractor will respond with the requested data within five (5) business days.

2.15.05 Reinsurance

The Contractor will be required to obtain reinsurance coverage from a source other than EOHHS. Proof of such reinsurance is a condition of contract award. EOHHS reserves the right to review the Contractor reinsurance coverage and to require changes to that coverage in the form of lower thresholds if considered necessary based on the Contractor's overall financial condition. The Contractor may not change the thresholds from those in ATTACHMENT K of this Agreement without the prior written consent of EOHHS.

2.15.06 Reserving

As part of its accounting and budgeting function, the Contractor will establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Contractor also will reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and reported but unpaid claims (RBUCs). As part of its reserving methodology, the Contractor will conduct "look backs" at least annually to assess its reserving methodology and make adjustments as necessary.

2.15.07 Claims Processing and MIS

The Contractor agrees to have claims processing system and Management Information System (MIS) sufficient to support the provider payment and data reporting requirements specified elsewhere in this contract. The Contractor also will be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of members.

2.15.08 Audits

In accordance with 42 CFR 438.242 and 438.602 (e), EOHHS, or its designees will conduct no less than once every three (3) years, with reasonable notice, any and all audit functions necessary to verify proper invoicing by the Contractor for provision of services, proper payments by EOHHS to the Contractor, and proper identification of TPL in accordance with this contract.

In the event that audit liabilities arising from any discrepancies in payments are discovered during the course of such audits, the net effect of which resulted in an overpayment to the Contractor, EOHHS may either:

- Make a demand for repayment of overpayment amount within thirty (30) calendar days
- Offset the amount of overpayment from invoices submitted to provide for payment and/or by the next monthly payment cycle.
- Refer the matter to the Department of Attorney General Medicaid Fraud Unit for investigation and/or seek interest in funds pursuant to RI General Laws Section 40-8.2-22.

In the event that audits discover underpayment to the Contractor, EOHHS will process a corrective payment within thirty (30) calendar days.

Any dispute or controversy encountered pursuant to this provision will be resolved pursuant to the guidelines specified herein.

2.15.09 Disproportionate Share Payments to Hospitals

The State will retain responsibility for disproportionate share payments to hospitals, if any. The Contractor will not be responsible for these payments.

2.15.10 Performance Goals

The purpose of performance measures is to ensure the Contractor provides eligible Medicaid beneficiaries with services that are high quality, accessible and promote positive health outcomes in a cost efficient and effective manner. The performance measures support the EOHHS Comprehensive Quality Strategy, Population Health Goals, and EOHHS vision, values, goals and priorities. The measures represent areas of opportunity for improvement and align with the RI Aligned Measure Set and the CMS Core Measures.

The performance measure program is for reporting purposes and is based on established benchmarks from the Quality Compass®. The goal is for the Contractor to achieve the benchmarks between the 75th and 90th percentile rate. The percentile rate measure should improve year to year. When the MCO consistently achieves the 90th percentile, or higher, on any given measure reporting requirements may be adjusted. A corrective action plan will be implemented for performance measures that fall below a preset acceptable level of achievement. If performance does not improve with the implementation of a corrective action plan, EOHHS can impose further corrective action as deemed appropriate.

Performance measures will be announced to the Contractor via electronic mail on an annual basis. The performance measure sets are subject to change based on performance in the prior year's

HEDIS and performance measures, as well as changes to the HEDIS, CMS Core Measure Sets, and/or the RI Aligned Measure Set.

2.15.11 Prohibited Payments

To conform to Section 1903(i)(10) of the Social Security Act (42 U.S.C. §1396b(i).) the Contractor is prohibited from paying for: 1) organ transplants unless the State Plan provides, and the Contractor follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees; 2) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; 3) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; 4) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act, 5) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished through the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act, 6) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

2.16 HEALTH PLAN FISCAL STANDARDS

2.16.01 General

The Department of Business Regulation regulates the financial stability of all licensed Health Plans in Rhode Island. The Contractor, therefore, agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific Medicaid Managed Care standards described in this Section.

2.16.02 Financial Benchmarks

The success of the Rhode Island Medicaid Managed Care program is contingent on the financial

stability of participating Health Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health Plans. The Contractor must provide documentation on a regular basis as outlined in this contract that the Contractor is financially solvent, has the capital, and has the financial resources and management capability to operate under this risk-based contract. The Contractor will demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

The Contractor agrees to provide all the information necessary for calculating benchmark levels. The Contractor also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

2.16.03 Financial Data Reporting

The Contractor agrees to comply with the *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Reporting Penalties.* Such compliance includes, but is not limited to, the submission of the following reports:

- Annual NAIC Financial Statements, including Risk Based Capital Reports;
- The Contractor's Annual Audited Financial Statements;
- The Contractor's Annual Report to Owners, Shareholders, members, and Others;
- Quarterly NAIC Financial Statements;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Claims Reinsurance Coverage and attachment points;
- Where applicable, evidence that the parent Company provides one hundred percent (100%) of subsidiary's financial backing.
- The Contractor's Risk/Gain Share Statements;
- Annual MLR Statement using the *Medicaid Managed Care Program: Medical Loss Ratio Calculation* workbook and template provided by EOHHS.
- AE Shared Savings Financial Performance Report
- Financial Data Cost Report
- Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Contractor's financial position or performance.

The Contractor agrees to comply in a timely and complete manner with all financial reporting requirements associated with the Accountable Entity (AE) Initiative.

2.16.04 Audit

In the case where the Agreement amount identified in Section 0 (Payments to and from Plans) is at least twenty-five thousand dollars ($25,000) in any year, the Contractor must submit an acceptable audited financial statement prepared by an independent auditor within twelve (12) months of the end of the Contractor's fiscal year. The audit must provide full and frank disclosure of all assets, liabilities, changes in fund balances, and all revenues and expenditures.

The Contractor will require that their external auditor, in the Annual Report of Independent Auditors, specifically address their review and testing of the Contractor's Risk Share/Gain Share financial reports and the Contractor's Receivable and/or Payable to/from EOHHS as of December 31 of each year.

The State retains the right to conduct, or cause to be conducted, specific audits. These audits may be conducted upon reasonable notification to the Contractor, and the audits would focus on matters related, but not limited, to:

- Invoicing by the Contractor for provisions of services;
- Payment to the Contractor by the State;
- Compliance with any of the terms and conditions of the Contract or Contract Amendments.

2.17 RECORDS RETENTION

2.17.01 General

The Contractor agrees to maintain and require its subcontractors to maintain books and records relating to Medicaid Managed Care services and expenditures covered under this Agreement, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, grievance and appeals records, medical loss ratio records and prescription files for a period of no less than ten (10) years.

The Contractor also agrees to comply with all standards for record keeping specified by the State. Operational data and medical record standards are described below. In addition, the Contractor must agree to permit inspection of its records under the terms specified in Section 2.15.07 (Claims Processing and MIS) and in ARTICLE III: CONTRACT TERMS AND CONDITIONS of the Agreement.

2.17.02 Operational Data Reports

The Contractor agrees to retain the source records for its data reports for a minimum of ten (10)

years and must have written policies and procedures for storing this information. Financial records must be retained for at least ten (10) years.

2.17.03 Medical Records

The Contractor agrees to preserve and maintain all medical records for a minimum of ten (10) years from expiration of this Agreement.

If records are related to a case in litigation, then these records should be retained during litigation and for a period of seven (7) years after the disposition of litigation.

2.18 COMPLIANCE

2.18.01 General Requirements

In accordance with 42 CFR 438.608[xxxii], the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the State and the Contractor, will have administrative and management arrangements, including a mandatory written compliance plan, which are designed to guard against fraud and abuse. An electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to the EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter.

The Contractor's compliance plan must address the following requirements:

- The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
- Effective training and education for the compliance officer, the Contractor's senior management, and the organization's employees for the federal and state standards and requirements under this contract.
- Effective lines of communication between the compliance officer and the Contractor's employees.
- Enforcement of standards through well-publicized disciplinary guideline.

- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including change in address and the death of a member.

- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

- Provisions to implement and verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers are received by member.

- Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements. Provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Act, including information about the rights of whistleblowers.

- Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the EOHHS Office of Program Integrity or any potential fraud directly to the EOHHS Fraud Control Unit.

- Provision for the notification to the State when it received information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor under 42 C.F.R. §438.608(a)(4).

- Provision to suspend payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 C.F.R. §455.23.

- Provision to ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455.400 et. seq.

2.18.02 Prohibited Affiliations with Individuals Debarred by Federal Agencies

In accordance with 42 CFR 438.610[xxxiii], the Contractor may not knowingly have a relationship with the following:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1) of this section.

The relationships described are as follows:

(1) A director, officer, or partner of the MCO.

(2) A subcontractor of the Contractor, as governed by 42 C.F.R. §438.230.

(3) A person with beneficial ownership of five (5) percent or more of the MCO's equity.

(4) A network provider or person with employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the State.

(5) An individual who is excluded from participation in any Federal Health care program under Section 1128 or 1128A of the Act.

(6) The State must ensure through its contracts that each MCO, PIHP, PAHP, PCCM and any subcontractors: (1) Provides written disclosure of any prohibited affiliation under 438.610; (2) provides written disclosures of information on ownership and control required under 455.104 and (3) reports to the state within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

2.18.03 Disclosure of the Contractor's Ownership and Control Interest

In accordance with 42 CFR 455.104, the Contractor must submit completed forms documenting full and complete disclosure of the Contractor's ownership and controlling interest, formatted in conformance with requirements established by EOHHS. Disclosures will be due at any of the following times:

(1) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(2) Upon the managed care entity executing the contract with the State.

(3) Upon renewal or extension of the contract.

(4) Within thirty-five (35) days after any change in ownership of the managed care entity. The following information will be disclosed by the Contractor, based on 42 CFR 455.104:

(i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity or managed care entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or managed care entity) or in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest.
(iv) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or managed care entity) is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
(v) The name of any other disclosing entity (or managed care entity) in which an owner of the disclosing entity (or managed care entity) has an ownership or control interest.
(vi) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or managed care entity).

The Contractor must keep copies of all ownership and control interest requests from EOHHS and the Contractor's responses to these disclosure requests. Copies of these requests and the Contractor's responses to them must be made available to the Secretary of the United States Department of Health and Human Services or to the EOHHS upon request. The Contractor must submit copies of the completed disclosure forms to the Secretary of the United States Department of Health and Human Services or to EOHHS within thirty-five (35) days of a written request.

2.18.04 Disclosure by Providers: Information on Ownership and Control

In accordance with 42 CFR 455.104, the Contractor must require each disclosing entity to disclose the following information:

(i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an

ownership or control interest in the disclosing entity (or managed care entity) or in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest.

(iv) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(v) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

(vi) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 C.F.R. Section 1001.2.

Any disclosing entity that is subject to periodic certification by the Contractor of compliance with Medicaid standards (such as at the time of initial credentialing and re-credentialing by the Contractor) must supply the information as specified in this section in conformance with requirements established by the EOHHS. Any disclosing entity that is not subject to periodic certification of its compliance within the prior 12-month period must submit the information to the Contractor before entering into a contract or agreement with the Contractor.

Disclosures must also be provided by any provider or disclosing entity at the following times:

- When the provider or disclosing entity submits a provider application;
- When the provider or disclosing entity executes a provider agreement with the State;
- Upon request of the State during the revalidation of the provider enrollment; and
- Within thirty-five (35) days after any change in ownership of the disclosing entity.

Updated information must be furnished to the Secretary of the United States Department of Health and Human Services or to EOHHS at intervals between recertification or contract renewals, within thirty-five (35) days of a written request.

The Contractor will not approve a provider agreement and must terminate an existing provider agreement or contract if the provider fails to disclose ownership or control information as required by this section.

2.18.05 Disclosure by Providers: Information Related to Business Transactions

In accordance with 42 CFR 455.105, the Contractor must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary of the United States Department of Health and Human Services or to EOHHS on request full and complete information related to business transactions.

A provider must submit, within thirty-five (35) days of the date of a request by the Secretary of the United States Department of Health and Human Services or the EOHHS, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than twenty-five thousand ($25,000) dollars during the 12-month period ending on the date of request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five year period ending on the date of the request.

This information must be submitted by a provider or a subcontractor to the Secretary of the United States Department of Health and Human Services or to the Rhode Island EOHHS within thirty-five (35) days of a written request.

2.18.06 Disclosure by Providers: Information on Persons Convicted of Crimes

In accordance with 42 CFR 455.106, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the provider must disclose the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of those programs.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR 1001.1001(a)(1).

The Contractor will promptly notify EOHHS in writing within ten (10) business days in the event that the Contractor identifies an excluded individual with an ownership or control interest.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of

the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

2.18.07 Disclosures Made by Providers to the Contractor

In accordance with 42 CFR 1002.3[xxxiv] and 42 CFR 1001.1001, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the Contractor will disclose to EOHHS in writing the identity of any person who:

(A) Has been convicted of a criminal offense as described in Sections 1128(b)(1) through (3) of the Social Security Act

(B) Has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act; or

(C) Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:

(1) A direct or indirect ownership interest of five (5) percent or more in the entity;

(2) Is the owner of a whole or part interest in any mortgage, deed of trust, note for other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceed five (5) percent of the total property and assets of the entity;

(3) Is an officer or director of the entity, if the entity is organized as a corporation;

(4) Is partner in the entity, if the entity is organized as a partnership;

(5) Is an agent of the entity; or

(6) Is a managing employee, that is (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or was formerly described in paragraph (a)(1)(ii)(A) of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in paragraph (a) (2) of this section, in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion.

For the purposes of this section, the following terms (agent, immediate family member, indirect ownership interest, member of household, and ownership interest) will have the meaning specified in 42 C.F.R. Section 1001.2:

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a ten (10) percent ownership interest in an entity at issue if he or she has a twenty (20) percent ownership interest in a corporation that wholly owns a subsidiary that is a fifty (50) percent owner of the entity in issue.)

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Ownership interest means an interest in:

(i) The capital, the stock, or the profits of the entity, or

(ii) Any mortgage, deed, trust or note, or other obligation secured in whole or party by the property or assets of the entity.

The Contractor must notify EOHHS in writing within ten (10) business days of the receipt of any disclosures which have been made to the Contractor.

The Contractor must promptly notify EOHHS in writing within ten (10) business days of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality. Provider credentialing requirements are addressed further in Section 2.12.05, Provider Credentialing.

The Contractor must also promptly notify EOHHS in writing within ten (10) business days of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

2.18.08 Compliance with all Rhode Island Regulations

The Contractor agrees to comply with all applicable RI State laws and regulations including but not limited to:

1. Effective 1/1/2017, R.I. Gen. Laws § 27-18-50.1, R.I. Gen. Laws § 27-19-26.1, R.I. Gen Laws § 27-20-23.1, and R.I. Gen. Laws § 27-41-38.1, Medication Synchronization

2. Effective 1/1/2017, R.I. Gen. Laws § 27-55-1 and R.I Gen. Laws 27-55-2, Off-Label Uses for Prescription Drugs

3. Effective 1/1/2018, R.I Gen. Laws § 27-18.9-8, External Appeals Procedural Requirements

4. Effective 17/1/19, Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies, SECTION 9, Chapter 40-8.4-20 "Health Care for Families", Continuous Coverage for Contraception.

2.18.09 Compliance with all Federal Regulations

The Contractor agrees to comply with all applicable Federal laws and regulations.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

3.01 GENERAL PROVISIONS

3.01.01 Contract Composition and Order of Precedence

Any submission made by the Contractor in response to the State's Letter of Intent (Bid Specifications) Document will be incorporated into this Agreement by reference. This Agreement will be in conformity with, and will be governed by, all applicable laws of the Federal government and the State of Rhode Island.

The component parts of the Agreement between the State of Rhode Island and the Contractor will, in addition to the foregoing, consist of ADDENDUM I-XIX and:

Schedule of In-Plan Benefits

ATTACHMENT A: Schedule of In-Plan Benefits
ATTACHMENT B: Schedule of Out-of-Plan Benefits
ATTACHMENT C: Schedule of Non-Covered Services
ATTACHMENT D: Rhode Island EPSDT Periodicity Schedule
ATTACHMENT E: Rhode Island Nutrition Standards
ATTACHMENT F: Extended Family Planning Benefits
ATTACHMENT G: FQHC and RHC Services
ATTACHMENT I: Contractor's Locations
ATTACHMENT J: Contractor's Capitation Rates SFY 2016
ATTACHMENT K: Contractor's Insurance Certificates
ATTACHMENT L: Rate-Setting Process
ATTACHMENT N: Special Terms and Conditions
ATTACHMENT O: Mental Health, Substance Use and Developmental Disability Services for Children
ATTACHMENT P: Behavioral Health and Substance Use Services for Adults
ATTACHMENT Q: Care Management Protocols for Members
ATTACHMENT U: Claims Based Data Elements

3.01.02 Integration Clause

This Agreement will represent the entire agreement between the parties and will supersede all prior negotiations, representations, or agreements, either written or oral, between the parties relating to the subject matter hereof. This Agreement will be independent of, and have no effect upon, any other contracts of either party, except as set forth to the contrary within.

3.01.03 Subsequent Conditions

The Contractor will comply with all requirements of this Agreement and the State will have no obligation to enroll any recipients into the Health Plan until such time as all of said requirements have been met.

3.01.04 Effective Date and Term

All terms and conditions stated herein are subject to final approval from CMS. This Agreement will be effective from March 1, 2017 and will be signed by the Contractor and the Rhode Island Executive Office of Health and Human Services and approved by CMS. The contract for five (5) years under the terms herein for the period March 1, 2017 to June 30, 2022 with five (5) one-year option periods, unless terminated prior to that date by provisions of this Agreement or extended by mutual agreement of the parties as provided for in this contract.

EOHHS may, at its discretion, defer the contractual operational start date for up to two (2) months beyond the scheduled start date of March 1, 2017 for a Contractor that has been approved in the initial review process but that fails to satisfy all readiness review requirements.

3.01.05 Contract Administration

This Agreement will be administered for the State by the Rhode Island Executive Office of Health and Human Services (EOHHS). The Medicaid Director or their appointee will serve as the responsible party for all matters related to this Agreement.

The Administrator, or his or her designee, will be the Contractor's primary liaison in working with other State staff and with the State's private program management contractor. In no instance will the Contractor refer any matter to Medicaid Director or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the Administrator or designee.

Whenever the State is required by the terms of this Agreement to provide written notice to the Contractor, such notice will be signed by the EOHHS Administrator or designee, or, in that individual's absence or inability to act, such notice will be signed by Medicaid Director. All notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in this Article will be issued by the EOHHS Administrator or designee.

3.01.06 Contract Officers

EOHHS will designate a Contract Officer. Such designation may be changed during the period of this Agreement only by written notice. The Contractor's Chief Executive Officer will be authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of this Agreement.

3.01.07 Liaisons

The Contractor will designate an employee of its administrative staff and EOHHS hereby designates its Contract Officer, who will act as liaisons, between the Contractor and EOHHS for the duration of the Agreement. The Contract Officer will receive all inquiries regarding this Agreement and all required reports. The Contractor also will designate a member of its senior management who will act as a liaison between the Contractor's senior management and EOHHS when such communication is required.

3.01.08 Notification of Administrative Changes

The Contractor will notify EOHHS of all changes materially affecting the delivery of care or the administration of its program. An example of such a material change would be a change which could affect the Contractor's ability to meet performance standards.

3.01.09 Notices

Any notice under this Agreement required to be given by one party to the other party, will be in writing and given by certified mail, return receipt requested postage pre-paid or overnight carrier which requires a receipt, of delivery in hand with a signed for receipt, and will be deemed given upon receipt.

Notices will be addressed as follows:

In case of notice to the Contractor: Chief Executive Officer

In case of notice to EOHHS: EOHHS Administrator, 3 West Road, Virks Building, Cranston, RI 02920

Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

3.01.10 Authority

Each party has full power and authority to enter into and perform this Agreement, except to the extent noted in Section 3.01.11, Federal Approval of Contract below, and by signing this Agreement, each party certifies that the person signing on its behalf has been properly authorized and empowered to enter into this Agreement. Each party further acknowledges that it has read this contract, understands it, and agrees to be bound by it.

3.01.11 Federal Approval of Contract

Under 42 CFR 438.6[i], CMS has final authority to approve all comprehensive risk contracts between states and contractors in which payment exceeds one-hundred thousand dollars ($100,000.00). If CMS does not approve a contract entered into under the Terms & Conditions described herein, the Agreement will be considered null and void.

3.01.12 Special Terms and Conditions

The Contractors will comply with the requirements specified in ATTACHMENT N of this Agreement.

3.02 INTERPRETATIONS AND DISPUTES

3.02.01 Conformance with State and Federal Regulations

The Contractor agrees to comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including those not specifically mentioned in this Article. In the event that the Contractor may, from time to time, request the State to make policy determinations or to issue operating guidelines required for proper performance of this Agreement, the State will do so in a timely manner, and the Contractor will be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and will incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

On May 6, 2016, following an extended period of review and public comment on proposed rules, CMS issued its final rule governing Medicaid managed care programs. (Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability). The final rule, as presented, is intended to modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery system. The Contractor is required to meet all regulations specified in 42 CFR 438.

3.02.02 Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement will be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party will have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties,

obligations, and undertakings.

Waiver of any breach of any term or condition in this Agreement will not be deemed a waiver of any prior or subsequent breach. No term or condition of this Agreement will be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

3.02.03 Severability

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and the Contractor will be relieved of all obligations arising under such provision; if the remainder of this Agreement is capable of performance, it will not be affected by such declaration or finding and will be fully performed. To this end, the terms and conditions defined in this Agreement can be declared severable.

3.02.04 Jurisdiction

This Agreement will be governed in all respects by the Laws and Regulation of the State of Rhode Island. The Contractor agrees to submit to the jurisdiction of the State of Rhode Island should any dispute, disagreement or any controversy of any kind arise or result out of the terms, conditions or interpretation of this Agreement. The Contractor, by signing this Agreement, agrees and submits to the jurisdiction of the courts of the State of Rhode Island and agrees that venue for any legal proceeding against the State regarding this Agreement will be filed in the Superior Court of Providence County.

3.02.05 Disputes

Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Chief Purchasing Officer of the State of Rhode Island is authorized, subject to any limitations or conditions imposed by regulations, to settle, compromise, pay, or otherwise adjust the dispute by or against or in controversy with, a Contractor relating to a contract entered into by the Department of Administration on behalf of the State or any State agency, including a claim or controversy based on contract, mistake, misrepresentation, or other cause for contract modification or rescission, but excluding any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official other than the Chief Purchasing Officer is specifically authorized to settle or determine such controversy.

A "contract dispute" will mean a circumstance whereby a Contractor and the State user agency are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of a contract.

The Chief Purchasing Officer will be authorized to resolve contract disputes between the Contractors and user agencies upon the submission of a request in writing from either party, which request will provide:

- A description of the problem, including all appropriate citations and references from the contract in question.

- A clear statement by the party requesting the decision of the Chief Purchasing Officer's interpretation of the contract.

- A proposed course of action to resolve the dispute.

The Chief Purchasing Officer will determine whether:

- The interpretation provided is appropriate.

- The proposed solution is feasible.

- Another solution may be negotiable.

If a dispute or controversy is not resolved by mutual agreement, the Chief Purchasing Officer or his designee will promptly issue a decision in writing after receipt of a request for dispute resolution. A copy of the decision will be mailed or otherwise furnished to the Contractor. If the Chief Purchasing Officer does not issue a written decision within thirty (30) days after written request for a final decision, or within such longer period as might be established by the parties to the contract in writing, then the Contractor may proceed as if an adverse decision had been received.

In the event an adverse decision is rendered, the Contractor may proceed to Superior Court and commence litigation against the State in accordance with Section 3.02.04 (Jurisdiction). If damages awarded on any contract claim under this section exceed the original amount of the contract, such excess will be limited to an amount which is equal to the amount of the original contract. No person, firm, or corporation will be permitted more than one (1) money recovery upon a claim for the enforcement of or for breach of contract with the State.

In no event, will the terms of this section apply to disputes between providers and the Contractor nor will the State be entitled to arbitrate such disputes.

Any fraudulent activity may result in criminal prosecution.

3.03 CONTRACT AMENDMENTS

3.03.01 General

The Executive Office may permit changes in the scope of services, time of performance, or approved budget of the Contractor to be performed hereunder. Such changes, which are mutually agreed upon by the Executive Office and the Contractor, must be in writing and will be made a

part of this agreement by numerically consecutive amendment excluding "Special Projects", if applicable, and are incorporated by reference into this Agreement.

Special Projects are defined as additional services available to the Executive Office on a time and materials basis with the amounts not to exceed the amounts referenced on the Contractor's RFP cost proposal or as negotiated by project or activity. The change order will specify the scope of the change and the expected completion date. Any change order will be subject to the same terms and conditions of this Agreement unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the length of this Agreement. Formal contract amendments will be negotiated by the State with the Contractor whenever necessary to address changes to the terms and conditions, the costs of, or the scope of work included under this Agreement. An approved contract amendment means one approved by EOHHS, the Contractor, and all other applicable State and Federal agencies prior to the effective date of such change.

An approved contract amendment will be in writing and will be signed by EOHHS, the Contractor and all other applicable State and Federal agencies prior to the effective date of the Amendment.

The Contractor agrees to provide a signed amendment no later than forty-five (45) calendar days after being provided the final Amendment by EOHHS. Failure to return a signed Amendment within forty-five (45) calendar days or to negotiate a new due date with EOHHS may result in, but not be limited to, a hold placed on the approval of member materials or suspension of auto-enrollment of members, to be in place until return of an executed copy of the Amendment.

The State and the Contractor will use contract amendments to reduce or increase Capitation Payments caused either through changes in the scope of benefits as a result of changes in Federal or State law or regulations or any other reason, scope of benefits otherwise covered by the State, the beneficiaries covered by this Agreement, and/or extension of the term of this Agreement. Annual adjustments in capitation payments will be made in conformance with actuarial soundness provisions found in 42 CFR 438.6(c)[xxxv] for actuarial soundness, for any applicable period of time, taking into account the budget neutrality limitations placed on Rhode Island Medicaid by CMS.

3.04 PAYMENT

3.04.01 Capitation Payments

The Contractor will receive Capitation Payments in the manner described in Section 2.15 (Payment To and From Plans) of this Agreement. All payments will be subject to the availability of funds. Adjustments to Capitation Payments due to member reconciliations will be made in the month following their discovery.

3.04.02 Fee-For-Service Payments

The State will reimburse the Contractor on a fee-for-service basis for covered services billed by the Contractor and not included within the pre-paid benefit package as described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement. The State will reimburse the Health Plan in the same manner it reimburses other fee-for-service providers.

3.04.03 Payments to Subcontractors and Providers

The State will bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Health Plan subcontractors, including providers and suppliers (see also Section 3.05.05, *Subcontracts*).

3.04.04 Liability for Payment

The Contractor agrees that members are not held liable as follows:

- The Contractor's debts, in the event of the Contractor's insolvency
- Covered services provided to the member, for which the State does not pay the Contractor, or the State, or the Contractor, does not pay the individual or the health care provider that furnishes the services under a contractual, referral, or other arrangement, or
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.

Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. EOHHS must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

3.04.05 Payments for Health System Transformation Project Incentives

EOHHS will make HSTP related payments to the Contractor as described in Section 2.08.02. All payments will be subject to the availability of funds.

3.04.06 Payments for Federal Qualified Health Centers (FQHCs) and Rural health Centers (RHCs)

If the Contractor includes FQHCs or RHCs in its provider network, Contractor is required to address cost issues related to the scope of services rendered by these providers and must reimburse FQHCs/RHCs either on a capitated (risk) basis considering adverse selection factors or on a cost related basis. The Contractor is required to reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers. The Contractor is required to ensure that the total revenue it provides to each FQHC/RHC is equal to the number of eligible encounters as outlined in EOHHS' "Principles of Reimbursement for Federally Qualified Health Centers" multiplied by that FQHCs/RHCs rate for the fiscal year, as shared by EOHHS. This funding is provided for in the rates.

3.05 GUARANTEES, WARRANTIES, AND CERTIFICATIONS

3.05.01 Contractor Certification of Truthfulness

By signing this Agreement, the Contractor certifies, under penalty of law, that the information provided herein is true, correct, and complete to the best of the Contractor's knowledge and belief. The Contractor acknowledges that should investigation at any time disclose any misrepresentation or falsification, this Agreement may be terminated by EOHHS upon written notice specifying the misrepresentation or falsification without penalty of further obligation by EOHHS.

3.05.02 Contractor Certification of Legality

The Contractor represents, to the best of its knowledge, that it has complied with and is complying with all applicable statutes, orders, and regulation promulgated by any Federal, State, municipal, or other governmental authority relating to its property and the conduct of operations; and, to the best of its knowledge, there are no violations of any statute, order, rule, or regulation existing or threatened.

3.05.03 Contractor Certification of HMO Licensure

The Contractor certifies that it meets all the requirements for a State-defined HMO as specified in the laws of Rhode Island and the rules of the Rhode Island Department of Business Regulation. If,

at any time during the term of this Agreement, the Contractor incurs loss of State approval and/or qualification as an HMO, such loss will be reported to EOHHS. Such loss may be grounds for termination of the Agreement under the provisions of Section 3.10 (Termination of the Contract).

If the Contractor is not a State-licensed HMO, the Contractor certifies that it meets the other requirements specified in Section 2.02 (Licensure, Accreditation, and Certification) of this Agreement. If the Contractor is not a State-licensed HMO and, at any time during the term of this Agreement, fails to meet the other requirements set forth in Section 2.02 (Licensure, Accreditation, and Certification) of this Agreement, such failure will be reported to EOHHS. Such failure may be grounds for termination of this Agreement under the provisions of Section 3.10.

3.05.04 Performance Bond or Substitutes

The Contractor will furnish a performance bond, a cash deposit, or an irrevocable letter of credit. The performance bond will be in a form acceptable to the State. If a cash deposit is used, it should be placed in different financial institutions to a maximum of one-hundred thousand dollars ($100,000.00) per deposit. If a letter of credit is used, the letter should be issued by a bank doing business in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation; a savings and loan institution doing business in the State of Rhode Island and insured by the Federal Savings and Loan Insurance Corporation; or a credit union doing business in the State of Rhode Island and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit, or letter of credit will be a minimum of one dollar for each capitation dollar paid in the month, or as determined by the EOHHS Administrator or designee. The total capitation amount will include projected SOBRA payments. The State will evaluate the enrollment statistics of the Contractor on a monthly basis. If there is an increase in the total capitation payment that exceeds 10 percent (10) above the previous month's total Capitation Payment, the State may require a commensurate increase in the amount of the performance bond, cash deposit, or letter of credit. The Contractor will have ten (10) business days to comply with any such increase.

The State may, at its discretion, permit the Contractor to offer substitute security in lieu of a performance, bond, cash deposit, or letter of credit. In that event, the Contractor will be solely responsible for establishing the credit worthiness of all forms of substitute security. The Contractor also will agree that the State may, after supplying written notice, withdraw its permission for substitute security, in which case the Contractor will provide the State with a form of security as described above. In the event of termination for default, the performance bond, cash deposit, letter of credit or substitute will become payable to the State for any outstanding damage assessments against the Contractor. Up to the full amount of the performance bond or substitute may also be applied to the Contractor's liability for any administrative costs and/or excess medical or other costs incurred by EOHHS in obtaining similar services to replace those terminated as a result of the default. The State may seek other remedies under law or equity in addition to this stated liability.

3.05.05 Subcontracts and Delegation of Duty

All subcontracts must be in writing and fulfill the requirements of 42 CFR 438.230[xxxvi] that are appropriate to the service or activity delegated under this Agreement. The Contractor will make available all subcontracts for inspection by the State, upon request. The Contractor may enter into written subcontract(s) for performance of certain contract responsibilities listed in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement. The Contractor must evaluate any prospective subcontractor's readiness and ability to perform the delegated contract responsibilities prior to assigning the activities by way of a detailed pre-delegation audit. The audit will encompass all duties and responsibilities that have been delegated to the subcontractor and will be evaluated for risk. The progress of the audit will be reported in a format and frequency specified by EOHHS. The audit must be completed and the results provided to EOHHS no less than thirty (30) business days prior to the scheduled "Go Live" date.

The HIPAA Privacy Rule requires that a covered entity obtain satisfactory assurances from its subcontracted and delegated entities that they will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other business associate agreement between the covered entity and the business associate.

The Contractor will monitor the performance of all subcontractors on an ongoing basis. This includes conducting formal reviews based on a schedule established by EOHHS and which is consistent with industry standards and State regulations. Both the Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.

The Contractor will be wholly responsible for performance of the entire contract whether or not subcontractors are used. In compliance with 42 CFR.438.230(b)(2)(ii), the Contractor must execute a written agreement with its subcontractors that specifies that Contractor's right to revoke the subcontract, and outlines reasons for the revocation of the contract, or specify other remedies in instances where the State or the Contractor determines that the subcontractor has not performed satisfactorily. The Contractor must also execute a written agreement which states that the Contractor may impose sanction on the subcontractor if the subcontractor's performance is inadequate. The Contractor must also execute a written agreement with their subcontractors which states that the subcontractor agrees that the State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General, or their authorized representatives, may audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State for ten (10) years from the final date of the contract period or from the date of the completion of any audit, whichever is later. If The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the

Attorney General, or their authorized representatives determine that there is a reasonable possibility of fraud, they may inspect, evaluate, and audit the subcontractors at any time. Any subcontract which the Contractor enters into with respect to performance under this Agreement will not relieve the Contractor in any way of responsibility for performance of its duties. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement (see also Section 3.05.06, *Assignment of the Contract*).

The Contractor will give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the Contractor or subcontractor that, in the opinion of the Contractor, may result in litigation related in any way to the Agreement with EOHHS.

Executive Order 92-4 encourages each State agency to meet a goal of ten percent (10%) of the dollar value of all procurement be awarded to small and small disadvantaged and minority and woman-owned businesses as subcontractors, pursuant to the provisions of Part 19 of Title 48, Federal Acquisition Regulations; 45 CFR 74.44, ATTACHMENT J: Capitation Rates; and Chapter 37-2.5.5.2.

The Contractor agrees, and will require its Subcontractors to agree, to subrogate to EOHHS any and all claims the Contractor has or may have against any provider, including but not limited to manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products, in actions brought against said Providers, etc., on behalf of EOHHS, through the Rhode Island Attorney General's Office. The Contractor is entitled to recoveries that are the direct result of a similar legal suit filed by the Contractor against the same party or parties that was initiated and properly filed prior to the date of a legal action initiated or joined by EOHHS or by Rhode Island Department of Attorney General.

In compliance with 42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(2)(xi), the Contractor agrees to inform providers and subcontractors to the following:

1. Enrollee's right to a state fair hearing,
2. How an enrollee can obtain a hearing,
3. Representation rules at a hearing
4. Right to file a grievance and appeal and,
5. The requirements and timeframe for filing a grievance and appeal
6. Right to request continuation of benefits during an appeal or State Fair Hearing filing but that the enrollee may be responsible for the cost of any continued benefit if the original action is upheld.
7. The toll-free number to file oral grievances and appeals.
8. State-determined provider's appeals rights to challenge the failure of an organization to cover a service.

All of the program standards described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS will apply to sub-contractors, to the extent relevant, to the duties they are performing. In addition, the provisions of the following ARTICLE III: CONTRACT TERMS

AND CONDITIONS clauses will apply to subcontractors:

Subsection 3.01.11	Federal Approval of Contract
Subsection 3.02.01	Conformance with State and Federal Regulations
Subsection 3.02.03	Severability
Subsection 3.05.07	Hold Harmless
Subsection 3.05.08	Insurance
Subsection 3.05.10	Patent or Copyright Infringement
Subsection 3.06.01	Employment Practices
Subsection 3.06.03	Independent Capacity of Contractor Personnel
Subsection 3.07.03	Fraud and Abuse
Subsection 3.08	Inspection of Work Performed
Subsection 3.09	Confidentiality of Information
Subsection 3.11.02	Ownership of Data and Reports

All requirements of this Section apply to subcontracts with Accountable-Entities. Additionally, subcontracts with AEs may not include delegation of network contracting, provider payment and/or claims processing, member services. The Contractor must ensure that the entities are in compliance with all member beneficiary protections, including notices, and appeal rights. The Contractor will have a written plan for monitoring and oversight of performance under these subcontracts, including provisions for assessing subcontract compliance and corrective actions and/or termination as appropriate. Such oversight will include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice. All risk-based subcontracts with Accountable Entities must ensure compliance with State and Federal regulations and must be approved by EOHHS.

3.05.06 Assignment of the Contract

The Contractor will not sell, transfer, assign, or otherwise dispose of this Agreement or any portion thereof or of any right, title, or interest therein without the prior written consent of the State. Such consent, if granted, will not relieve the Contractor of its responsibilities under this Agreement. This provision includes reassignment of this Agreement due to change in ownership of the firm. State consent will not be unreasonably withheld.

3.05.07 Hold Harmless

The Contractor will indemnify and hold the State of Rhode Island, its Executive Offices, agencies, branches and its or their officers, directors, agents or employees (together the "Indemnities" and their subcontractors) harmless against from:

- Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract.

- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by the Contractor, its officers, employees, or subcontractors in the performance of the contract.

- Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the contract in a manner not authorized by the contract or by Federal or State regulations or statutes.

- Any failure of the Contractor, its officers, employees, or subcontractors to observe the Federal or State laws, including, but not limited to, labor laws and minimum wage laws.

- Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

Before delivering services under this Agreement, the Contractor will provide adequate demonstration to the State that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 3.05.08, Insurance.

The Contractor may elect to self-insure any portion of the risk assumed under the provision of this Agreement based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse financial actions, including withholding of payment or imposition of damages by the State.

3.05.08 Insurance

Before delivering services under this Agreement, the Contractor will obtain, from an insurance company duly authorized to do business in Rhode Island, the minimum coverage levels described below for:

- Professional liability insurance
- Workers' compensation
- Comprehensive liability insurance
- Property damage insurance
- Errors and Omissions insurance
- Reinsurance

ATTACHMENT K of this Agreement contains the Contractor's Certificates of Insurance. Each certificate states the policy, the insured, and the insurance period. Each of the Contractor's insurance policies will contain a clause, which requires the State be notified ten (10) days prior to cancellation.

The Contractor will be in compliance with all applicable insurance laws of the State of Rhode Island and of the Federal Government throughout the duration of this Agreement.

3.05.08.01 Professional Liability Insurance

The Contractor will obtain and maintain, for the duration of this Agreement, professional liability insurance in the amount of at least one-million dollars ($1,000,000.00) for each occurrence.

3.05.08.02 Workers' Compensation

The Contractor will obtain and maintain, for the duration of this Agreement, workers' compensation insurance for all of its employees employed in Rhode Island. In the event any work is subcontracted, the Contractor will require the subcontractor similarly to provide workers' compensation insurance for all the latter's employees employed at any site in Rhode Island, unless such subcontractor's employees are covered by the workers' compensation protection afforded by the Contractor. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State of Rhode Island.

3.05.08.03 Minimum Liability and Property Damage Insurance

The Contractor will obtain, pay for, and keep in force general liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of one-million dollars ($1,000,000.00) for any one (1) occurrence; and insurance against liability for property damages, as well as first-party fire insurance, including contents coverage for all records maintained pursuant to this Agreement, in the amount of five-hundred thousand dollars ($500,000.00) for each occurrence; and such insurance coverage that will protect the State against liability from other types of damages, for up to five-hundred thousand dollars ($500,000.00) for each occurrence.

3.05.08.04 Errors and Omissions Insurance

The Contractor will obtain, pay for, and keep in force for the duration of the contract Errors and Omissions insurance in the amount of one-million dollars ($1,000,000.00).

3.05.08.05 Reinsurance

The Contractor will obtain, pay for, and keep in force reinsurance for the reimbursement of excess costs incurred by a member. The level at which the Contractor establishes reinsurance must be consistent with sound business practices under the financial condition of the Contractor. The Contractor may not change the thresholds from those submitted in response to the bid solicitation and incorporated into ATTACHMENT K of this Agreement without the prior written consent of

the State.

3.05.08.06 Evidence of Coverage

The Contractor will furnish to the State upon request a certificate(s) evidencing that required insurance is in effect, for what amounts, and applicable policy numbers and expiration dates prior to start of work under the Agreement. In the event of cancellation of any insurance coverage, the Contractor will immediately notify the State of such cancellation. The Contractor will provide the State with written notice at least ten (10) days prior to any change in the insurance required under this subsection.

The Contractor will also require that each of its subcontractors maintain insurance coverage as specified above or provide coverage for each subcontractor's liability and employees. The provisions of this clause will not be deemed to limit the liability or responsibility of the Contractor or any of its subcontractors hereunder.

3.05.09 Force Majeure

Neither the Contractor nor the State will be liable for any damages or excess costs for failure to perform their contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by the Contractor or the State. Such causes may include, but are not restricted to, fires, earthquakes, tornadoes, floods, unusually severe weather, or other catastrophic natural events or acts of God: quarantine restrictions; explosions; subsequent legislation by the State of Rhode Island or the Federal government; strikes other than the Contractor's employees; and freight embargoes. In all cases, the failure to perform must be beyond reasonable control of, and without fault or negligence of, either party.

3.05.10 Patent or Copyright Infringement

The Contractor will represent that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from the Contractor's use of any equipment, materials, computer software and products, or information prepared by or on behalf of the Contractor, or developed in connection with the Contractor's performance of this Agreement, then the Contractor will, at its expense, defend such claim or suit. The Contractor will satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with the Contractor's right of approval.

3.05.11 Clinical Laboratory Improvement Amendments (CLIA) Of 1988

All laboratory testing sites providing services under this Agreement have either a Clinical

Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the tests permitted under the terms of their CLIA waiver from CMS' Division of Laboratory Services. Laboratories with certificates of registration may perform a full range of laboratory tests. The Contractor will require all subcontractors and participating providers to conform to this requirement.

3.05.12 Sterilization, Hysterectomy, and Abortion Procedures

The Contractor will follow Rhode Island Medicaid policy and consent procedures on sterilizations, hysterectomy, and abortion services for members. Members may self-refer to in-network providers for allowable abortion services.

3.05.13 Payments to Institutions or Entities Located Outside of the U.S.

In compliance with 42 CFR 438.602(i), the Contractor must be located within the U.S. The Contractor will make no payments to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. The Contractor will issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The Contractor is prohibited from making payments to telemedicine providers and pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

3.06 PERSONNEL

3.06.01 Employment Practices

The Contractor will agree to comply with the requirements relating to fair employment practices, to the extent applicable and agrees further to include a similar provision in any and all subcontracts. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap. The Contractor will take affirmative action to ensure that employees, as well as applicants for employment, are treated without regard to their race, color, religion, sex, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Such action will be taken in areas including, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

The Contractor will agree to post in a conspicuous place, available to employees and applicants for employment, notices setting forth the provision of this non-discrimination clause. The

Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, age (except as provided by law), marital status, political affiliation, or handicap, except where it relates to bona fide occupational qualification. The Contractor will send to each labor union or representative of workers with which he has a collective bargaining arrangement or other agreement or understanding, a notice advising the labor union or workers' representative of the Contractor's commitments under Section 202 of Executive Order No. 11246 of September 24, 1976, as amended, and the rules, regulations, and relevant orders of the Secretary of Labor.

The Contractor will agree to comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 USC 2000D et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794); Title IX of the Education Amendments of 1972 (20 USC 1681 et seq.); Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.); The Food Stamp Act, and the Age Discrimination Act of 1975; the United States Department of Health and Human Services regulations found in 45 CFR, parts 80 and 84; the United States Department of Education implementing regulations (34 CFR, parts 104 and 106) which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities; and the United States Department of Agriculture, Food and Nutrition Services (7 CFR 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, political beliefs, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities, or as any of the Acts are amended from time to time.

The Contractor will comply with all provisions of Executive Order No. 11246 of September 24, 1976, as amended, and of the rules, regulations, and relevant orders of the Secretary of Labor. The Contractor will furnish all information and reports required by Executive Order No. 11246 of September 24, 1976, as amended, and by the rules, regulations, and orders of the Secretary of Labor or pursuant thereto and will permit access to its books, records, and accounts by the Secretary of the U.S. Department of Health and Human Services and the U.S. Secretary of Labor or their authorized representatives for purposes of investigation to ascertain compliance with rules, regulations, and orders.

The Contractor will comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Orders 11625 and 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor will comply with regulations issued by the Secretary of Labor of the United States in Title 20, Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758 and the Federal Rehabilitation Act of 1973. The Contractor will be responsible for ensuring that all subcontractors comply with the above-mentioned regulations. The Contractor and its subcontractors will comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Vocational Rehabilitation Act of 1973, as amended.

The Contractor will comply with all applicable provisions of Stat. 53-1147, the Federal "Hatch

Act," as amended.

The Contractor will comply with all applicable provisions of Public Law 101-336, Americans with Disabilities Act.

Pursuant to Title VI and Section 504, as listed above and as referenced in ADDENDUM II and ADDENDUM III, which are incorporated herein by reference and made part of this Agreement, the Contractor will have policies and procedures in effect, including, mandatory written compliance plans, which are designed to assure compliance with Title VI section 504, as referenced above. An electronic copy of the Contractor's written compliance plan, all relevant policies, procedures, workflows, relevant chart of responsible personnel, and/or self-assessments must be available to EOHHS upon request.

The Contractor's written compliance plans and/or self-assessments, referenced above and detailed in ADDENDUM II and ADDENDUM III of this Agreement must include but are not limited to the requirements detailed in ADDENDUM II and ADDENDUM III of this Agreement.

The Contractor must submit, within thirty-five (35) days of the date of a request by DHHS or EOHHS, full and complete information on Title VI and/or Section 504 compliance and/or self-assessments, as referenced above, by the Contractor and/or any subcontractor or vendor of the Contractor.

The Contractor acknowledges receipt of ADDENDUM II - Notice to executive office of health and human services' service providers of their responsibilities under TITLE VI of the civil rights act of 1964 and ADDENDUM VI - Notice to executive office of health and human services' service providers of their responsibilities under section 504 of the Rehabilitation Act of 1973, which are incorporated herein by reference and made part of this Agreement.

The Contractor further agrees to comply with all other provisions applicable to law, including the Americans with Disabilities Act of 1990; the Governor's Executive Order No. 05-01, Promotion of Equal Opportunity and the Prevention of Sexual Harassment in State Government.

The Contractor also agrees to comply with the requirements of the Executive Office of Health and Human Services for safeguarding of client information as such requirements are made known to the Contractor at the time of this contract. Changes to any of the requirements contained herein will constitute a change and be handled in accordance with the Contract Amendments noted in Section 3.03.

Failure to comply with this Paragraph may be the basis for cancellation of this Agreement.

The Contractor will agree to comply with all other State and Federal statutes and regulations that are or may be applicable and that are not specifically mentioned above.

3.06.02 Employment of State Personnel

The Contractor will not knowingly engage on a full-time, part-time, or other basis, during the period of this Agreement, any professional or technical personnel who are, or have been at any time during the period of this Agreement, State employees, except those regularly retired individuals, without prior written approval from the EOHHS Administrator or designee. Such approval will not be unreasonably withheld.

The penalty for violation of the above conditions will result in a two thousand, five hundred dollars ($2,500.00) penalty per employee, plus an added two thousand five hundred ($2,500.00) penalty per month, per employee if the Contractor or subcontractor fails to terminate the employee after they have been notified in writing of the violation by the State's designated contract administrator.

3.06.03 Independent Capacity of Contractor Personnel

It is expressly agreed that the Contractor or any subcontractor involved in the performance of this Agreement will act in an independent capacity and not as an agent, officer, employee, partner, or associate of the State of Rhode Island. The Contractor staff will not hold themselves out as nor claim to be officers or employees of the State of Rhode Island by reason hereto. It is further expressly agreed that this Agreement will not be construed as a partnership or joint venture between the Contractor or any subcontractor and the State.

3.07 PERFORMANCE STANDARDS AND DAMAGES

3.07.01 Performance Standards for Medicaid Managed Care

The performance standards for Health Plans will be defined as substantial compliance with the program requirements specified in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS and the Attachments of this Contract. The Contractor agrees to cooperate fully with the State in its efforts to monitor and assess compliance with these performance standards. The Contractor will cooperate fully with the State or its designees in efforts to validate performance measures.

Failure to comply with the provisions of this section may subject the Contractor to intermediate sanctions including: (1) civil monetary penalties, as described in Section 3.07.04; (2) appointment of temporary management of the Health Plan, as provided for in 42 CFR 438.706[xxxvii]; (3) granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll; (4) suspension of new enrollment including automatic assignment after the effective date of the sanction; and/or (5) suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

3.07.02 Suspension of New Enrollment

Whenever the State determines that the Contractor, any of its delegated entities or subcontractors

are in material breach of the performance standards described in Section 3.07.01, it may suspend the Contractor's right to enroll new members. The State, when exercising this option, will notify the Contractor in writing of its intent to suspend new enrollment. The suspension period may be for a reasonable length of time specified by the State, depending on the severity and circumstances of the breach. The State also may notify enrollees of the Contractor non-performance and permit these enrollees to transition to another Health Plan.

3.07.03 Fraud and Abuse

3.07.03.01 General Requirements

The Contractor will establish and maintain internal controls which are designed and executed to prevent, detect, investigate, and report suspected Medicaid Fraud and Abuse that may be committed by network providers, non-network providers, vendors, subcontractors, employees, members, or other third parties with whom the Contractor contracts. The Contractor will comply with all Federal and State requirements regarding Medicaid fraud and abuse, including but not limited to Sections 1124, 1126(b)(1), 1126(b)(2), 1126(b)(3), 1128, 1156, 1892, 1902(a)(68), and 1903(i)(2) of the Social Security Act and Section 40-8.2- 2 of the General Laws of Rhode Island. EOHHS and its Office of Program Integrity may conduct audits at any time on the Contractor's formal fraud, waste and abuse program as well as any files as a result of claims audits.

The Contractor will cooperate fully with any investigations, including providing information, access to records, and access to interview the Contractor employees and consultants at the time determined by the State. Provider contracts with the Contractor will incorporate these terms and conditions.

The following terms (abuse, conviction or convicted, exclusion, fraud, furnished, practitioner, and suspension) will have the meaning specified in 42 C.F.R. §438.2. Credible Allegation of Fraud is defined as, an allegation from any source, including but not limited to the following:

(1) Fraud hotline complaints.

(2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability.
An electronic copy of the Contractor's written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse must be submitted to the Rhode Island EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter.

3.07.03.02 Mandatory Components of Employee Education about False Claims Recovery

In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Contractor receives more than five million dollars ($5,000,000) in Medicaid payments on an annual basis, then it must establish and disseminate written policies for all employees, including management and any subcontractor or agent of the Contractor, that include detailed information about the False Claims Act, established under sections 3279 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act).

Section 6032 of the Deficit Reduction Act establishes section 1902(a)(68) of the Social Security Act, which relates to "Employee Education about False Claims Recovery". The Contractor's written policies pertaining to employee education about false claims recovery may be on paper or in electronic form but must be readily available to all of the Contractor's employees, contractors, or agents. The Contractor's policies and procedures must include detailed information about the prevention and detection of Medicaid waste, fraud, and abuse.

The Contractor will also include in any employee handbook a specific discussion of the laws described in the written policies and the rights of employees to be protected as whistleblowers. The employee handbook must also include a specific discussion of the Contractor's policies and procedures for preventing and detecting fraud, waste, and abuse.

3.07.03.03 Member Education about Medicaid Fraud and Abuse

The Contractor will educate its members about Medicaid fraud and abuse by including this subject matter in the contractor's member handbook. This content will address examples of possible Medicaid fraud and abuse by providers or vendors, as well by enrollees, and must be pre-approved by EOHHS.

In its member handbook, the Contractor will also inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free telephone number established by the Contractor for reporting possible Medicaid fraud and abuse, as well as information about how to contact EOHHS's Fraud Unit.

These member handbook requirements are addressed further in Section Required Information (Required Information).

3.07.03.04 Recipient Verification Procedures

In accordance with 42 CFR 455.20, the Contractor will be responsible for establishing procedures to verify with enrollees whether services billed by providers and vendors were received. Recipient verification requirements specific to workflows for the generation and dissemination of explanation of member benefits (EOMB) are addressed further in Section 3:07.03.05 (Explanation

of Member Benefits).

The Contractor will document its recipient verification procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter. These recipient verification procedures may include but not be limited to the following:

- Informing enrollees in writing when goods or services have been prior authorized by the Contractor
- Notifying enrollees in writing when services which may require a concurrent authorization (such as a continued inpatient length of stay) have been approved by the Contractor
- Engaging in targeted outreach to enrollees whose pattern of health services utilization may warrant enrollment in any of the Contractor's care coordination or complex case management programs

Recipient verification procedures should delineate how the Contractor will respond to feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.07.03.06 (Investigating and Reporting Suspected Fraud and Abuse).

3.07.03.05 Explanation of Member Benefits

The Contractor will, in conformance with sampling requirements established by EOHHS, issue individual notices within forty-five (45) days of the payment of claims, to a sample of enrollees who received goods or services. The Contractor will omit from its sampling pool any claims that are associated with confidential services (as defined by the State).

These notices, or explanation of member benefits, must specify the following:

- The service furnished
- The name of the provider furnishing the service
- The date on which the service was furnished
- The amount of the payment made for the service

The Contractor will document its EOMB procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter. The EOMB procedures should delineate how the Contractor will respond to subsequent feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.07.03.06 (Investigating and Reporting Suspected Fraud and Abuse).

3.07.03.06 Investigating and Reporting Suspected Fraud and Abuse

The Contractor will have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by 42 CFR 456.3, 456.4, and 456.23. The Contractor will initiate an investigation of possible Medicaid fraud and abuse based upon a variety of data sources, including but not limited to the following:

- Claims data mining to identify aberrant billing patterns
- Feedback from enrollees based upon EOMB transmittal processes
- Calls received on the Contractor's toll-free telephone number for reporting possible Medicaid fraud and abuse
- Peer profiling and provider credentialing functions
- Analyses of utilization management reports and prior authorization requests
- Monthly reviews of the CMS' List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM)
- Queries from State or Federal agencies

The Contractor is required to report any suspected cases of provider or vendor fraud and/or waste and abuse within five (5) business days, following the conclusion of its initial investigation, to the EOHHS Medicaid Contract Officer and/or designee as well as the Office of Program Integrity (PI). PI will review and process the referral and if there is a credible allegation of fraud, submit to the Rhode Island Attorney General MFCU and/or request additional evidence from the Health Plan.

The Contractor will have sufficient and dedicated staff in their Special Investigations Unit (SIU) and/or auditing unit. The Contractor will provide EOHHS and/or PI with the name and contact information of the designated individual within their SIU with whom the State or PI may:

- Communicate with directly; and

- Receive access to staff that are working to identify and resolve specific investigations, audits or cases of suspected fraud

The Office of Program Integrity (PI) may initiate meetings in addition to the quarterly Medicaid Fraud Control Unit meetings (MFCU) to engage in case discussions and to facilitate closure of outstanding investigations.

The Contractor, after reporting fraud or suspected fraud, will not take any of the following actions:

- Contact the subject; or
- Negotiate any settlement or agreement; or
- Accept any monetary or other thing of valuable in connection with the incident.

The Contractor will have a process for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. The Contractor will check with both the Office of Program Integrity, (OPI) and EOHHS before initiating any recoupment related to the outcome of a program integrity audit or prior to implementing any withhold of any funds for program integrity related issues.

While all recoveries related to overpayments due to fraud, waste or abuse, except of whistle blower cases, are retained by the Contractor, the Contractor will develop retention policies for the treatment of recoveries. The Contractor must provide an annual report of any monetary recoveries that result from reconciliation of cases of fraud.

In addition, the Contract will complete the State's updated reporting form and report quarterly run recoupments against the anticipated findings.

The Contractor will utilize EOHHS' quarterly MCO Program Integrity Report to report ongoing running totals of recoupments associated with individual cases as the mechanism by which to report the total recoupment for all cases within the calendar year.

3.07.03.06.01 Notifications and Tips

The Contractor will utilize the State provided template to make a referral in a secure, timely, and thoughtful manner as well as to alert both EOHHS and PI of a notification or "tip." In addition to reporting any suspected cases of provider or vendor fraud and/or abuse within five (5) business days following the close of an initial investigation, the Contractor will also submit quarterly reports to EOHHS documenting the Contractor's open and closed cases. Along with a notification, the Contractor will take steps to triage and/or substantiate these tips and provide timely updates when the concerns and/or allegations of any tips are authenticated.

The Contractor will notify the Office of Program Integrity in a timely manner regarding all incidents and/or concerns regarding the safety of its members.

The Contractor will cooperate fully in any investigation or prosecution. Such cooperation will include, but not be limited to, providing, upon request, information, access to records, and claims data.

3.07.03.06.02 Program Integrity Audits

The Office of Program Integrity reserves the right to conduct on-site audits of the Contractor's fraud and abuse/SIU unit and program integrity activities.

3.07.04 Damages

The Contractor will use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties under this Agreement. The Contractor will be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement, up to a maximum cap of One Hundred Thousand Dollars ($100,000); provided, however, that the Contractor agrees to indemnify and hold harmless EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of the Contractor or its employees, acting alone or in collusion with others; and provided, further, that this maximum cap on damages will not apply in the event that the loss arises in a situation in which the Contractor failed to follow its own policies and procedures.

The maximum civil monetary penalty levied will be in conformance with 42 CFR 438.704[xxxviii].

3.07.04.01 Non-Compliance with Program Standards

The Contractor will ensure that performance standards as described in Section 3.07.01 are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of this Agreement with respect to performance standards, unless otherwise specified below, damages will be assessed against the Contractor in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. When the non-compliance results in transfer of members to another Health Plan, the damages will include a maximum amount equal to the difference in the capitation rates paid to the Contractor and the rates paid to the replacement Health Plan. Damages will not be imposed until such time that the State has notified the Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

3.07.04.02 Non-Compliance with Monthly Reconciliation Tasks

The Contractor will carry out the monthly member reconciliation tasks as described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS. The Contractor will be liable for the actual

amount of any detected overpayments or duplicate payments identified as a result of State or Federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect Contractor action in conducting monthly member reconciliation.

3.07.04.03 Non-Compliance with Data Reporting Standards

Contractor shall comply with the operational and financial data reporting requirements described respectively in the document entitled *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Reporting Penalties* and Sections 2.13.01, 2.16.03, and 2.17.02 of this Agreement.. Included is any ad hoc reporting requested for the purpose of investigating fraud or abuse or to validate data in the State's data warehouse. In addition, all reports provided to EOHHS will be attested to individually by the Contractor. The Contractor is required to submit a report timely, accurately, in the correct template and/or with the proper naming convention and must remedy any error within three (3) business days of notification of the error form EOHHS.

3.07.04.04 Basis for Imposition of Intermediate Sanctions

EOHHS may impose intermediate sanctions on the Contractor as specified in 42 C.F.R. § 438.700[xxxix] and 42 CFR 438.702[xl] if it makes any of the determinations specified in paragraphs (a) through (c). The EOHHS may base its determinations on findings from onsite surveys, member or other complaints, financial status, or any other source.

(a) EOHHS determines that the Contractor has acted or failed to act as follows:
   1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Agreement with the EOHHS, to a Member covered under this Agreement.
   2. Imposes on members' premiums or charges that are in excess of any permitted by the EOHHS.
   3. Acts to discriminate against Members on the basis of their health status or need for health care services. This includes the termination of enrollment or refusal to reenroll a Member, except as permitted by the EOHHS, or any practice that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.
   4. Misrepresents or falsifies information that it furnishes to CMS or to the EOHHS.
   5. Misrepresents of falsifies information that it furnishes to a Member, a potential Member, or health care provider.
   6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208[xxvii] and 422.210.

(b) EOHHS determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the EOHHS or that contain false or materially misleading information.

(c) EOHHS determines that:

1. The Contractor has violated any of the other applicable requires of sections 1932. 1903(m) or 1905(t)(3) of the Social Security Act and any implementing regulations;
2. For any of the violations under 42 CFR 438.700(d)(1) and (2), only the sanctions specified in 42 CFR 438.702(a)(3), (4) and (5) may be imposed.

3.07.04.05 Types of Intermediate Sanctions

EOHHS may impose the following types of intermediate sanctions:

1. Civil monetary penalties in the amounts specified in 42 CFR 438.704[xxxviii].
2. Appointment of temporary management for the Contractor as specified 42 CFR 438.706[xxxvii].
3. Granting members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll.
4. Suspension of all new enrollment, including default enrollment, after the date the CMS or the EOHHS notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
5. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

EOHHS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700[xxxix], as well as any additional areas of noncompliance. As set for in 42 CFR 438.710(a), EOHHS will provide the Contractor written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

3.07.04.06 Amount of Civil Monetary Penalties

The limit on, or the maximum civil monetary penalty EOHHS may impose varies depending on the nature of the Contractor's action or failure to act, as provided in this section.

1. The limit is $25,000 for each determination under the following paragraphs of 42 CFR 438.700[xxxix]:
   i. Paragraph (b)(1): Failure to provide services.

ii. Paragraph (b)(5): Misrepresentation or false statements to Members, potential Members, or health care providers.
iii. Paragraph (b)(6): Failure to comply with physician incentive plan requirements.
iv. Paragraph (c): Marketing violations.

2. The limit is $100,000 for each determination under the following paragraphs of 42 CFR 438.700[xxxix]:
   i. Paragraph (b)(3): Discrimination.
   ii. Paragraph (b)(4): Misrepresentation or false statements to CMS or to the EOHHS.

The limit is $15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice under paragraph (b)(3) of 42 CFR 438.700[xxxix]. This is subject to the overall limit of $100,000 under paragraph (b)(3) of this section.

3.07.04.07 Compliance with Other Material Contract Provisions

The objective of this standard is to provide the State with an administrative procedure to address general compliance issues under this Agreement which are not specifically defined as performance requirements listed above or for which damages due to non-compliance cannot be quantified in the manner described in Section 3.07.04.01.

The State may identify contractual compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the EOHHS Administrator or designee will notify the Contractor in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than thirty (30) calendar days, in which the Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the Contractor should remedy the non-compliance, but not less than thirty (30) days.

If the non-compliance is not corrected by the specified date, the State may assess damages up to the amount of two thousand five hundred dollars ($2,500.00) per day after the due date until the non-compliance is corrected.

3.07.05 Deduction of Damages from Payments

Amounts due the State as damages may be deducted by the State from any money payable to the Contractor pursuant to this Agreement. The Contract Administrator will notify the Contractor in writing of any claim for damages at least fifteen (15) days prior to the date the State deducts such sums from money payable to the Contractor.

The State may, at its sole discretion, return a portion or all of any damages collected as an incentive payment to the Contractor for prompt and lasting correction of performance deficiencies.

3.07.06 Payments Denied by CMS

The State may recommend that CMS impose a denial of payment for new enrollees pursuant to 42 CFR 438.730. If the State's determination becomes CMS' determination, the State will:

- Provide the Contractor with written notice of the basis of the proposed sanction.
- All the Contractor fifteen (15) days from the date it received the notice to provide evidence contesting the basis for the sanction.
- Conduct a reconsideration, if requested by the Contractor
- Provide the Contractor a written decision setting forth the basis for the reconsideration decision.

If the Contractor does not seek reconsideration, the denial of payment will be effective fifteen (15) days after the date the Contractor is notified.

3.07.07 Intermediate Sanctions

EOHHS may establish intermediate sanctions, as specified in CFR 438.702 and 438.704, which it will impose if it makes any of the following determinations or findings from onsite surveys, enrollee or other complaints, financial status or any other source:

1. EOHHS determines that a Contractor acts or fails to act as follows:
   a. Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of discrimination.
   b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater.
   c. Acts to discriminate among enrollees on the basis of their health status or need for health care services; the limit is $15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice, subject to an overall limit of $100,000.
   d. Misrepresents or falsifies information that it furnishes to CMS or to EOHHS; EOHHS may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation.
   e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider; EOHHS may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation.

f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210; EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.
g. EOHHS determines whether the Contractor has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by EOHHS or that contain false or materially misleading information. EOHHS may impose a civil monetary penalty of up to $25,000 for each failure to comply.
h. EOHHS determines whether the Contractor has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

In addition to any civil monetary penalty levied against the Contractor, EOHHS may also:

- Appoint temporary management to the Contractor;
- Grant Members the right to disenroll without cause;
- Suspend all new enrollment to the Contractor;
- Suspend payment for new enrollments to the Contractor

As set for in 42 CFR 438.710(a), EOHHS will give the Contractor written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

3.07.08 COMPLIANCE AUDIT AND CORRECTIVE ACTION

The Annual Compliance Audit will be onsite and consists of a focused review of key elements of the Contractor's compliance program (42 CFR 438.608) [xxxii] and will assess adherence to the Contractor's written compliance plan including all relevant operating policies, procedures, workflows, and relevant chart of organization. The key elements reviewed may vary from year to year. A review of administrative and management arrangements may also be conducted as part of the annual audit. A review of grievance and appeal files will be a standard part of the compliance audit.

EOHHS will provide feedback to Contractor on the audit elements. If the audit reveals issues of noncompliance, EOHHS, at its discretion, will make the determination if a corrective action plan will be required to remediate any issues of noncompliance.

Issues of noncompliance and/ or under performance by the Contractor or their sub-contractors, either self-reported, discovered through audit or identified by EOHHS may, at the State's discretion, may require implementation of a Corrective Action Plan. Dependent on the severity of the issue of noncompliance and/or underperformance by the Contractor, EOHHS will implement Corrective Action Plan in accordance with time frames established by EOHHS. If the issue(s) of noncompliance and/or underperformance warrants continued monitoring or the issue(s) has

occurred previously within the same contract year, EOHHS at its discretion, can require ongoing monitoring throughout the life of the contract or impose specific reporting to be submitted not otherwise stated in this Contract.

3.08 INSPECTION OF WORK PERFORMED

3.08.01 Access to Information

Pursuant to Section 434.6(a)(5), EOHHS, other state agencies, and/or its designees, including its management and external quality review organization contractors, the Medicaid Fraud Unit of the Department of Attorney General, and CMS and/or its designees, will have access to medical information, quality of service information, financial information (including claim level detail), service delivery information including authorization requests and denials or other adverse decisions, complaints, grievances and appeals information, and other such information of the Contractor, and its subcontractors and agents in order to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed and reimbursed for under this Agreement and in compliance with this Agreement. The Contractor agrees to accommodate requests for access to this information which may be submitted at any time. Subcontractors must agree to comply with all applicable requirements, such as those pertaining to reporting responsibilities, record-keeping, state and federal audits. For audit purposes, subcontractors are subject to a 10-year record retention period for which EOHHS may request access to.

3.08.02 Inspection of Premises

The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General or their authorized representatives will, during normal business hours, have the right to enter into the premises of the Contractor and/or all subcontractors and providers, or such other places where duties under this Agreement are being performed, to inspect, monitor, or otherwise evaluate the work being performed.

Such inspections may include, but not be limited to, the CMS or State-mandated annual operational and financial Health Plan reviews, determinations of compliance with this Agreement, and CMS or State-mandated independent evaluations. All inspections and evaluations will be performed in such a manner as to not unduly interfere with or delay work.

3.08.03 Approval of Written Materials

The Contractor agrees to submit to EOHHS for review and approval all materials in any media. The Contractor produces for dissemination to actual and potential members including but not

limited to materials produced for recipient education, outreach, marketing, the member handbook, and written grievance procedures. EOHHS will review such documents in draft form and determine whether to grant approval for the Contractor to disseminate such documents to the recipient population.

The Contractor's policies and procedures pertaining to the program covered under this Agreement produced for dissemination to actual and potential members, including but not limited to procedures for determining eligibility for coverage as a related group, also will be subject to inspection and approval by the State.

3.09 CONFIDENTIALITY OF INFORMATION

3.09.01 Maintain Confidentiality of Information

The Contractor will take security measures to protect against the improper use, loss, access of and disclosure of any confidential information it may receive or have access to under this Agreement as required by this Agreement, the RFP and proposal, or which becomes available to the Contractor in carrying out this Agreement and the RFP and the proposal, and agrees to comply with the requirements of the EOHHS for safeguarding of client and such aforementioned information. Confidential information includes, but is not limited to: names, dates of birth, home and/or business addresses, social security numbers, protected health information, financial and/or salary information, employment information, statistical, personal, technical and other data and information relating to the State of Rhode Island data, and other such data protected by the office laws, regulations and policies ("confidential information"), as well as State and Federal laws and regulations. All such information will be protected by the Contractor from unauthorized use and disclosure and will be protected through the observance of the same or more effective procedural requirements as are applicable to the EOHHS.

The Contractor expressly agrees and acknowledges that said confidential information provided to and/or transferred to provider by the EOHHS or to which the Contractor has access to for the performance of this Agreement is the sole property of the EOHHS and will not be disclosed and/or used or misused and/or provided and/or accessed by any other individual(s), entity(ies) and/or party(ies) without the express written consent of the EOHHS. Further, the Contractor expressly agrees to forthwith return to the EOHHS any and all said data and/or information and/or confidential information and/or database upon the EOHHS's written request and/or cancellation and/or termination of this Agreement.

The Contractor will not be required under the provisions of this paragraph to keep confidential any data or information, which is or becomes legitimately publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of this Agreement or is rightfully obtained from third parties under no obligation of confidentiality.

The Contractor agrees to abide by all applicable, current and as amended Federal and State laws and regulations governing the confidentiality of information, including to but not limited to the

Business Associate requirements of HIPAA (WWW.HHS.GOV/OCR/HIPAA), to which it may have access pursuant to the terms of this Agreement. In addition, the Contractor agrees to comply with the EOHHS confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information. ("Confidential records" are the records as defined in section 38-2-3(d) of the Rhode Island General Laws, entitled "access to public records" and described in "access to Department of Health records.")

In accordance with this Agreement and all Addenda thereto, the Contractor will additionally receive, have access to, or be exposed to certain documents, records, that are confidential, privileged or otherwise protected from disclosure, including, but not limited to: personal information; Personally Identifiable Information (PII), Sensitive Information (SI), and other information (including electronically stored information), records sufficient to identify an applicant for or recipient of government benefits; preliminary draft, notes, impressions, memoranda, working papers-and work product of state employees; as well as any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court ("State Confidential Information"). State Confidential Information also includes PII and SI as it pertains to any public assistance recipients as well as retailers within the SNAP Program and Providers within any of the State Public Assistance programs.

Personally Identifiable Information (PII) is defined as any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual. (As defined in 45 CFR 160.103).

Sensitive Information (SI) is information that is considered sensitive if the loss of confidentiality, integrity, or availability could be expected to have a serious, severe or catastrophic adverse effect on organizational operations, organizational assets, or individuals. Further, the loss of sensitive information, confidentiality, integrity, or availability might: (i) cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions; (ii) result in significant or major damage to organizational assets; (iii) result in significant or major financial loss; or (iv) result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life threatening injuries. (Defined in HHS Memorandum ISP-2007-005, "Departmental Standard for the Definition of Sensitive Information").

The Contractor agrees to adhere to any and all applicable State and Federal statutes and regulations relating to confidential health care and substance Use treatment including but not limited to the Federal Regulation 42 CFR, Part 2; Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26; Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq., and HIPAA 45 CFR Part 160[xli] and 164. The Contractor acknowledges that failure to comply with the provisions of this paragraph will result in the termination of this Agreement.

EOHHS requires the Contractor to adhere to the provisions of the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, as well as guidelines found in the "Health Information Technology for Economic and Clinical Health Act" (HITECH). The Contractor will require HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information and must specify the requirements of these notifications to the HIPAA covered entities and business associates. In addition, EOHHS requires the Contractor to notify EOHHS immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use of disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality or integrity of enrollee PHI maintained or held by the Contractor, including unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. Additionally, a breach or suspected breach may be an actual or suspected acquisition, access, use of, or disclosure of PII or SI. This includes, but is not limited to, loss or suspected loss of remote computing or telework devised such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs and/or disks. Notification to EOHHS' designated security officer will be made by telephone call and e-mail. The Contractor will, within three (3) business days, provide to the EOHHS's designated security officer an updated status of the breach. A full report is required to be submitted to EOHHS's designated security officer within sixty (60) calendar days and will include a full accounting of the incident along with a corrective action plan.

Upon notice of a suspected security incident, the EOHHS and the Contractor will meet to jointly develop an incident investigation and remediation plan. Depending on the nature and severity of the confirmed breach, the plan may include the use of an independent third-party security firm to perform an objective security audit in accordance with recognized cyber security industry commercially reasonable practices. The parties will consider the scope, severity and impact of the security incident to determine the scope and duration of the third-party audit. If the parties cannot agree on either the need for or the scope of such audit, then the matter will be escalated to senior officials of each organization for resolution. The Contractor will pay the costs of all such audits. Depending on the nature and scope of the security incident, remedies may include, among other things, information to individuals on obtaining credit reports and notification to applicable credit card companies, notification to the local office of the Secret Service, and or affected users and other applicable parties, utilization of a call center and the offering of credit monitoring services on a selected basis.

Notwithstanding any other requirement set out in this Agreement, the Contractor acknowledges and agrees that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements will be implemented by regulations to be adopted by the U.S. Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and its implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

Failure to abide by the EOHHS's confidentiality policy or the required signed Business Associate Agreement (BAA) will result in termination remedies, including but not limited to, termination of this Agreement. A Business Associate Agreement (BAA) will be signed by the Contractor, simultaneously or as soon thereafter as possible, from the signing of this Agreement, as required by the EOHHS.

3.09.02 Confidentiality of Information

The Contractor agrees that all information, records and data collected in connection with this contract will be protected from unauthorized disclosures and will be used by the Contractor personnel solely for purposes directly connected with the Contractor's performance of this Agreement. In addition, the Contractor agrees to safeguard the confidentiality of qualified member information. Access to member identifying information will be limited by the Contractor to persons, Health Plans or agencies, which require the information in order to perform their duties in accordance with this Agreement.

Any other person or entity will be granted access to confidential information only after complying with the requirements of the State and Federal laws and regulations pertaining to such access. Nothing herein will prohibit the disclosure of information in summary, statistical or other form, which does not identify the particular individuals.

The Contractor agrees to comply with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42U.S.C. Section 1320d, et seq., and regulations promulgated there under, as amended from time to time (statute and regulations hereinafter collectively referred to as the "privacy rule").

The Contractor's obligations and responsibilities:

(a) The Contractor agrees to not use or disclose protected health information other than is permitted or required by the agreement or as required by law.

(b) The Contractor agrees to use appropriate and most updated industry safeguards to prevent use or disclosure of the protected health information other than as provided by this agreement.

(c) The Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or a disclosure of protected health information by the Contractor in violation of requirement of this Agreement.

(d) The Contractor agrees to report to EOHHS any use or disclosure of the protected health information not provided for by this Agreement of which it becomes aware.

(e) The Contractor agrees to maintain the security of protected health information it receives by establishing, at a minimum, measures utilized in current industry standards.

(f) The Contractor agrees to notify EOHHS immediately upon becoming aware of a suspected or actual breach of security that may result or has resulted in the use or disclosure of protected health and other confidential information for purposes other than such proposed as specified in this Agreement.

(g) The Contractor agrees to prepare and maintain a plan, subject to review by EOHHS /Do IT upon request, specifying the method that the Contractor will employ to mitigate immediately, to extent practicable, any harmful effects that may or have been caused by such a breach.

(h) The Contractor agrees that EOHHS will be held harmless in the event of such a breach and the Contractor accepts fully the legal and financial responsibility associated with mitigating any harmful effects that may or have been caused.

(i) The Contractor agrees that it is subject to and will ensure compliance with all HIPAA regulations in effect at the time of this Agreement and as will be amended under HIPAA from time to time, and any and all reporting requirements required by HIPAA at the time of this Agreement and as will be amended, under HIPAA from time to time. As well as ensuring compliance with the Rhode Island Confidentiality of Health Care Information Act, Rhode Island General Laws, Section 5-37.3 seq.

(j) The Contractor agrees to implement policies and procedures to facilitate the removal, termination and final disposal of PHI in electronic format, including the storage media housing the information.

3.09.03 Assurance of Security and Confidentiality

Each party agrees to take reasonable steps to ensure the physical security of such data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files; guards; or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; such as passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; such as limited terminal access; limited access to input documents and output documents; and design provisions to limit use of client or applicant names.

Each party agrees that it will inform each of its employees having any involvement with personal data or other confidential information, whether with regards to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

In the event of the Contractor's failure to conform to requirements set forth above, EOHHS may terminate this Agreement under the provisions of Section 3.10 (Termination of the Contract).

3.09.04 Return of Confidential Data

The Contractor agrees to return all personal data furnished pursuant to this Agreement promptly at the request of the State in whatever form is maintained by the Contractor. Upon the termination or completion of the Agreement, the Contractor will not use any such data, or any material derived from the data for any purpose not permitted by law and where so instructed by the State will destroy such data or material if permitted by law.

3.09.05 Hold Harmless

The Contractor agrees to defend (subject to the approval of the Attorney General), indemnify, and hold harmless EOHHS and the State against any claim, loss, damage, or liability incurred as a result of any breach of the obligations of Section 3.09 by the Contractor or any subcontractor.

3.09.06 State Assurance of Confidentiality

The State agrees to ensure Federal and State laws of confidentiality are maintained to protect member and provider information.

3.09.07 Publicizing Safeguarding Requirements

Pursuant to 42 CFR 431.304, the Contractor agrees to publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use. The Contractor will include these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

3.09.08 Types of Information to Be Safeguarded

Pursuant to 42 CFR 431.305 and HIPAA, and subject to any permitted uses under this Agreement, the Contractor agrees to maintain the confidentiality of recipient information regarding at least the following:

- Names, addresses, and social security numbers
- Physical and behavioral health services provided
- Social and economic conditions or circumstances
- EOHHS evaluations of personal information
- Medical data, including diagnosis and past history of diseases or disability and
- Any information received in connection with the identification of legally liable third-party resources

Pursuant to 42 CFR 431.305 and HIPAA, the State agrees to maintain the confidentiality of recipient information regarding at least the following:

- Any information received for verifying income eligibility and amount of Medicaid payments
- Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data

3.09.09 Confidentiality and Protection of Public Health Information and Related Data

The Contractor will be required to execute a Business Associate Agreement Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, will require the successful Contractor to comply with 45 CFR 164.502(e), 164.504(e), 164.410[xlii], governing Protected Health Information ("PHI") and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated there under, and as amended from time to time the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, RI general Laws Section 5-37.3 et seq.

Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

The Contractor will be required to ensure, in writing that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this Agreement, agrees to have the same restrictions and conditions that apply through the above described Agreements with respect to such information.

3.10 TERMINATION OF THE CONTRACT

This Agreement between the parties may be terminated only on the following basis:

- By mutual written agreement of the State and the Contractor
- By the State, or by the Contractor, in whole or in part, whenever one party determines that the other party has failed to satisfactorily perform its contracted material duties and

responsibilities and is unable to cure such failure within a reasonable period of time after receipt of a notice specifying that material breach.

- By the State, or the Contractor, in whole or in part, whenever funding from State, Federal, or other sources is withdrawn, reduced, or limited, with at least sixty (60) days prior written notice.

- By the State, in whole or in part, whenever the State reasonably determines, based on adequate documentation, that the instability of the Contractor's financial condition threatens delivery of covered services and continued performance of the Contractor responsibilities.

- Upon a finding of just cause, if the State will determine that such termination is in the best interest of the State, with sufficient prior notice to the Contractor.

- By either party pursuant to Section 3.05.03 (Contractor Certification of HMO Licensure) of this Agreement

As specified in 42 CFR 438.710(b), prior to terminating this Agreement, EOHHS will provide the Contractor with written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing. After the hearing, EOHHS will provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the contract. If the decision to terminate is affirmed, EOHHS will provide the Contractor with the effective date of the termination. If the decision to terminate is affirmed, EOHHS will notify members of the termination and their options for receiving Medicaid services following the effective date of the termination and allow members to disenroll without cause.

3.10.01 Termination for Default

The State or the Contractor may terminate this Agreement, in whole or in part, whenever either reasonably determines that the other party has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within a reasonable period of time as specified in writing by the State or the Contractor, as applicable. Such termination will be referred to herein as "Termination for Default."

Upon reasonable determination by the State or the Contractor that the other party (the "Defaulting Party") has failed to satisfactorily perform its contracted duties and responsibilities, the Defaulting Party will be notified in writing, by either certified or registered mail, of the failure. If the Defaulting Party is unable to cure the failure within sixty (60) days following the receipt of notice of default, unless a different time period is agreed to by the parties in writing, the State or the Contractor, as applicable, will notify the Defaulting Party that this Agreement, in whole or in part, has been terminated for default.

If, after notice of Termination for Default, it is determined by the State or the Contractor, as

applicable, or by a court of law of competent jurisdiction that the Defaulting Party was not in default or that the Defaulting Party's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Defaulting Party, the termination will be deemed to be governed by Section 3.05.09 (Force Majeure) of this Agreement.

In the event of termination for default by the State, in full or in part as provided under this clause, the State may cover, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor will be liable for any costs for such similar supplies or services and all other damages allowed by law. In addition, the Contractor will be liable to the State for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. Payment for such costs may be assessed against the Contractor's performance bond or substitute security.

In the event of a termination for default by the State, the Contractor will be paid for any outstanding monies due less any assessed damages. If damages exceed monies due from invoices, collection can be made from the Contractor's performance bond, cash deposit, letter of credit, or substitute security.

The rights and remedies of the State provided in this clause will not be exclusive and are in addition to any other rights and remedies provided by law or under the contract.

In the event of Termination for Default by the Contractor, in whole or in part as provided under this clause, the Contractor immediately may close to new enrollment that has been initiated but not yet completed as of the date specified in the notice of termination), without reduction of the premium rate for the then-current enrollees as provided in
ATTACHMENT J. The Contractor will be paid for any capitation or other monies due through the date specified in the notice of termination, including risk sharing payment, within ninety (90) days of termination. The rights and remedies of the Contractor provided in this clause will not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

Any fraudulent activities may result in criminal prosecution.

3.10.02 Termination for Unavailability of Funds

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated contract expiration date, the State may terminate this Agreement upon at least thirty (30) days prior written notice.

In the event that the State elects to terminate this Agreement pursuant to this provision, the Contractor will be notified in writing by either certified or registered mail either thirty (30) days or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination will be effective as of the close of business on the date specified in the notice.

Upon receipt of notice of termination for unavailability of funds, the Contractor will be paid for any outstanding monies due.

3.10.03 Termination for Financial Instability

In the event that the State reasonably determines, based on adequate documentation, that the Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under this Agreement, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Agreement effective the close of business on the date specified. In the event the State elects to terminate this Agreement under this provision, the Contractor will be notified in writing by either certified or registered mail specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor will immediately advise the Contract Administrator. The Contractor will ensure that all tasks related to the subcontract are performed in accordance with the terms of this Agreement.

3.10.04 Termination for Convenience

If the Contractor intends to terminate the Agreement pursuant to this Article or allow the Agreement to expire, it must give EOHHS advance written notice at least one year prior to the proposed termination or expiration. The termination date will be calculated as the last Day of the month following the one-year notice period. The Parties can negotiate an earlier termination date by mutual written agreement.
The Contractor will work in good faith with the EOHHS and the EOHHS' other Medicaid managed care Contractors to ensure the safe and orderly transition of the Contractor's Members into a new Health Plan.

3.10.05 Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective or upon expiration of this Agreement, the Contractor will:

- Stop work under this Agreement on the date and to the extent specified in the Notice of Termination or upon expiration of this Agreement.
- With the approval of the State, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts or from such expiration, the cost of which would be reimbursable in whole or in part, in accordance with the provision of this Agreement.

- If applicable, complete the performance of such part of the work as has not been terminated by any Notice of Termination.

- Provide all reasonably necessary assistance to the State in transitioning members out of the Health Plan generally, upon expiration of the Agreement, or to the extent specified in the Notice of Termination. Such assistance will include, but not be limited to, the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized and pregnant members in their last four weeks of pregnancy. The transition of any and all data will be delivered at no cost and in a format determined by EOHHS.

- Provide to the State on a monthly basis, until the earlier of six (6) months from the termination or expiration or instructed otherwise, a monthly, claims aging report by provider/creditor that includes IBNR amounts; a monthly summary of cash disbursements; and copies of all bank statements received by the Contractor in the preceding month. Such reports will be due on the fifteenth (15th) working day of each month for the prior month.

3.10.06 Refunds of Advance Payments

The Contractor will return within thirty (30) days of receipt any funds advanced for coverage of members for periods after the date of termination or expiration.

3.10.07 Liability for Medical Claims

The Contractor will be liable for all medical claims incurred up to the date of termination. This will include the hospital inpatient claims incurred for members hospitalized at the time of termination. In the event of termination of solvency, the Contractor is responsible for payment for services received by members in any month for which capitation was paid, as well as for the relevant portion of inpatient services for members hospitalized at time of termination.

3.10.08 Termination Claims

After receipt of a Notice of Termination, the Contractor will submit any termination claims in the form and with the certifications prescribed by the State. Such claims will be submitted promptly, but in no event later than six (6) months from the effective date of termination, unless one or more extensions in writing are granted by the State within such six- (6) month period or authorized extension thereof.

Subject to the timeliness provisions in the previous paragraph, and subject to any review required by State procedures in effect as of the date of execution of the contract, the Contractor and State may agree upon the amounts to be paid to the Contractor by reason of the total or partial

termination of work. This Agreement will be amended accordingly (see Section 3.03, *Contract Amendments*).

In the event of a failure to agree in whole or in part as to the amounts to be paid to the Contractor in connection with the total or partial termination of work pursuant to this Article, the State will determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and will pay to the Contractor the amount so determined. The Contractor will have the right of appeal, as stated under Section 3.02.05, (Disputes), of any such determination.

However, if the State determines that the facts justify such action, termination claims may be accepted and acted upon at any time after such six (6) month period or any extension thereof. Upon failure of the Contractor to submit its termination claim within the time allowed, the State may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine on the basis of information available the amount, if any, due to the Contractor by reason of the termination and will pay to the Contractor the amount so determined.

In no case will the Contractor's termination claims include any claim for unrealized anticipatory profits.

3.10.09 Notification of members

In the event that this Agreement is terminated for any reasons outlined in above, or in the event that this Agreement is not renewed for any reason, EOHHS in consultation with the Contractor regarding the content of any notice (such consultation to occur prior to the sending of any notice) will be responsible for notifying all members covered under this Agreement of the date of termination and the process by which those members will continue to receive Covered Services.

3.10.10 Non-Compete Covenant

EOHHS may cancel this Agreement without penalty, if any person significantly involved in negotiating, securing, drafting, or creating this Agreement on behalf of the State is or becomes at any time, while this Agreement or any extension of this Agreement is in effect, an employee of any party to this Agreement in any capacity or a consultant to the Contractor or Subcontractor with respect to the subject matter in this Agreement. Cancellation will be effective when written notice from EOHHS is received by the Contractor unless the notice specifies a later time.

3.11 OTHER CONTRACT TERMS AND CONDITIONS

3.11.01 Environmental Protection

The Contractor will comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), Section 508 of the Clean Water Act (33 USC

1368), Executive Order 11738, and Environmental Protection Agency regulations which prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable grantor Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

3.11.02 Ownership of Data and Reports

Data, information, and reports collected or prepared directly for the State by the Contractor in the course of performing its duties and obligations under this Agreement will be deemed to be owned by the State of Rhode Island. This provision is made in consideration of the Contractor's use of public funds in collecting or preparing such data, information, and reports. Nothing contained herein will be deemed to grant to the State ownership or other rights in the Contractor's proprietary information systems or technology used in conjunction with this Agreement.

3.11.03 Publicity

Any publicity given to the program or services provided herein, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor, will identify the State of Rhode Island as the sponsor and will not be released without prior written approval from the State.

3.11.04 Award of Related Contracts

The State may undertake other contracts for work related to this Agreement or any portion thereof. Examples of other such contracts include, but are not limited to, contracts with other Health Plans to provide Medicaid Managed Care services and contracts with management firms to assist in administration of this Agreement. The Contractor will be bound to cooperate fully with such other Contractors as directed by the State in all such cases. All subcontractors will be required to abide by this provision as a condition of the contract between the subcontractor and the prime Contractor.

3.11.05 Conflict of Interest

No official or employee of the State of Rhode Island or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement will, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. All State employees will be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

The Contractor represents and covenants that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that, in the performance of the contract, no person having any such known interests will be employed.

3.11.06 Reporting of Political Contributions

In accordance with Rhode Island Executive Order 91-31, any Contractor who obtains a State contract or purchase order for goods or services, and whose charges to the State exceed two thousand five hundred dollars ($2,500.00) in any State fiscal year, is required to file a form declaring the vendor's political contributions in excess of two hundred dollars ($200.00) to candidates for State offices or the General Assembly. Upon payment to a Contractor being made in excess of two thousand five hundred dollars ($2,500.00) year-to-date, the Contractor will receive a form prepared by the Secretary of State upon which to make such declaration. The Contractor will update such form as future political contributions subject to this reporting requirement are made. Failure to complete or update said form accurately, completely, and in conformance with its terms, or to file it with the Secretary of State within sixty (60) days of receipt, will amount to a violation of these terms and conditions and may render the Contractor ineligible for further State contracts. Additional disclosure forms, as may be required, may be obtained from the office of the Secretary of State.

3.11.07 Environmental Tobacco Smoke

The Contractor will comply with Public Law 103-227, Part C—Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

3.11.08 Titles Not Controlling

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and will not be construed to infer a contractual construction of language.

3.11.09 Other Contracts

Nothing contained in this Agreement will be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor will provide EOHHS with a complete list of such plans and services, including rates, upon request. Nothing in this Agreement will be construed to prevent EOHHS from contracting with other comprehensive health care plans in the same enrollment area. EOHHS shall not disclose any proprietary information pursuant to this information except as required by law.

3.11.10 Counterparts

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

3.11.11 Administrative Procedures Not Covered

Administrative procedures not provided for in this Agreement will be set forth where necessary in separate memoranda from time to time in accordance with Section 3.01.09.

These administrative procedures will include but will not be limited to participation in meetings and file exchanges with Health Source RI, the Unified Health Information Project (UHIP) and all other vendors and subcontractors involved in implementing the Medicaid eligibility system in RI.

IN WITNESS HEREOF, the parties have caused this Agreement to be executed under Seal by their duly authorized officers or representatives as of the day and year stated below:

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES:

BY:

Womazetta Jones Digitally signed by Womazetta Jones Date: 2022.03.02 16:26:46 -05'00'

(Signature)

Womazetta Jones

(Printed Name)

Secretary

(Title)

3/2/2022

(Date)

TUFTS HEALTH PUBLIC PLANS:

BY: Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:22:23 -05'00'

(Signature)

Jean Yang

(Printed Name)

President, Public Plans

(Official Title)

February 28, 2022

(Date)

ADDENDUM I

FISCAL ASSURANCES

1. THE CONTRACTOR AGREES TO SEGREGATE ALL RECEIPTS AND DISBURSEMENTS PERTAINING TO THIS AGREEMENT FROM RECEIPTS AND DISBURSEMENTS FROM ALL OTHER SOURCES, WHETHER BY SEPARATE ACCOUNTS OR BY UTILIZING A FISCAL CODE SYSTEM.

2. THE CONTRACTOR ASSURES A SYSTEM OF ADEQUATE INTERNAL CONTROL WILL BE IMPLEMENTED TO ENSURE A SEPARATION OF DUTIES IN ALL CASH TRANSACTIONS.

3. THE CONTRACTOR ASSURES THE EXISTENCE OF AN AUDIT TRAIL WHICH INCLUDES: CANCELLED CHECKS, VOUCHER AUTHORIZATION, INVOICES, RECEIVING REPORTS, AND TIME DISTRIBUTION REPORTS.

4. THE CONTRACTOR ASSURES A SEPARATE SUBSIDIARY LEDGER OF EQUIPMENT AND PROPERTY WILL BE MAINTAINED.

5. THE CONTRACTOR AGREES ANY UNEXPENDED FUNDS FROM THIS AGREEMENT ARE TO BE RETURNED TO THE DEPARTMENT AT THE END OF THE TIME OF PERFORMANCE UNLESS THE DEPARTMENT GIVES WRITTEN CONSENT FOR THEIR RETENTION.

6. THE CONTRACTOR ASSURES INSURANCE COVERAGE IS IN EFFECT IN THE FOLLOWING CATEGORIES: BONDING, VEHICLES, FIRE AND THEFT, LIABILITY AND WORKER'S COMPENSATION.

7. THE FOLLOWING FEDERAL REQUIREMENTS WILL APPLY AS INDICATED:

- _ OMB CIRCULAR A-21 COST PRINCIPLES FOR EDUCATIONAL INSTITUTIONS
- _ OMB CIRCULAR A-87 COST PRINCIPLES APPLICABLE TO GRANTS AND CONTRACTS WITH STATE AND LOCAL GOVERNMENTS
- _ OMB CIRCULAR A-102 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS-TO-AID TO STATE AND LOCAL GOVERNMENTS
- X OMB CIRCULAR A-110 UNIFORM ADMINISTRATIVE

REQUIREMENTS FOR GRANTS AND AGREEMENTS WITH INSTITUTIONS OF HIGHER EDUCATION, HOSPITALS, AND OTHER NONPROFIT ORGANIZATIONS

X OMB CIRCULAR A-122 COST PRINCIPLES FOR NONPROFIT ORGANIZATIONS

8. IF THE CONTRACTOR EXPENDS FEDERAL AWARDS DURING THE PROVIDER'S PARTICULAR FISCAL YEAR OF $500,000 OR MORE, THEN OMB CIRCULAR A-133, AUDITS OF STATES, LOCAL GOVERNMENTS AND NON-PROFIT ORGANIZATIONS WILL ALSO APPLY.

9. THIS AGREEMENT MAY BE FUNDED IN WHOLE OR IN PART WITH FEDERAL FUNDS. IF SO, THE CFDA REFERENCE NUMBER IS 93.778.

ADDENDUM II

NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH EOHHS ARE SUBJECT TO THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH IS LOCATED AT 45 CFR, PART 80, COLLECTIVELY REFERRED TO HERINAFTER AS TITLE VI. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE A CONTRACTOR'S ASSURANCE THAT IN COMPLIANCE WITH TITLE VI AND THE IMPLEMENTING REGULATIONS, NO PERSON WILL BE EXCLUDED FROM PARTICIPATION IN, DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN ITS PROGRAMS AND ACTIVITIES ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. ADDITIONAL DHHS GUIDANCE IS LOCATED AT 68 FR 47311-02.

EOHHS RESERVES ITS RIGHT TO AT ANY TIME REVIEW SERVICE CONTRACTOR TO ASSURE THAT THEY ARE COMPLYING WITH THESE REQUIREMENTS. FURTHER, EOHHS RESERVES ITS RIGHT TO AT ANY TIME REQUIRE FROM SERVICE PROVIDER'S CONTRACTORS, SUB-CONTRACTORS AND VENDORS THAT THEY ARE ALSO COMPLYING WITH TITLE VI.

THE CONTRACTOR WILL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH TITLE VI. AN ELECTRONIC COPY OF THE SERVICE PROVIDERS WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

THE CONTRACTOR'S WRITTEN COMPLIANCE PLAN MUST ADDRESS THE FOLLOWING REQUIREMENTS:

- WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL TITLE VI STANDARDS.
- DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE SERVICE PROVIDER'S SENIOR MANAGEMENT.
- EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.
- ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.

- PROVISION FOR INTERNAL MONITORING AND AUDITING.
- WRITTEN COMPLAINT PROCEDURES
- PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.
- PROVISION THAT ALL CONTRACTORS, SUB-CONTRACTORS AND VENDORS
  OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID CONTRACTORS, SUB-CONTRACTORS AND VENDORS ARE IN COMPLAINCE WITH TITLE VI.

THE CONTRACTOR MUST ENTER INTO AN AGREEMENT WITH EACH CONTRACTOR, SUB-CONTRACTOR OR VENDOR UNDER WHICH THERE IS THE PROVISION TO FURNISH TO IT, DHHS OR EOHHS ON REQUEST FULL AND COMPLETE INFORMATION RELATED TO TITLE VI COMPLIANCE.

THE CONTRACTOR MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAYS OF THE DATE OF A REQUEST BY DHHS OR EOHHS, FULL AND COMPLETE INFORMATION ON TITLE VI COMPLAINCE BY THE CONTRACTOR AND/OR ANY CONTRACTOR, SUB-CONTRACTOR OR VENDOR OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH CONTRACTOR TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE TITLE VI REGULATIONS. A COPY OF THE REGULATIONS IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, **RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES/DEPARTMENT OF HUMAN SERVICES,** 57 HOWARD AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER: (401) 462-2130.

THE REGULATIONS ADDRESS THE FOLLOWING TOPICS:

SECTION:
80.1 PURPOSE
80.2 APPLICATION OF THIS REGULATION
80.3 DISCRIMINATION PROHIBITED
80.4 ASSURANCES REQUIRED
80.5 ILLUSTRATIVE APPLICATIONS
80.6 COMPLIANCE INFORMATION
80.7 CONDUCT OF INVESTIGATIONS
80.8 PROCEDURE FOR EFFECTING COMPLIANCE
80.9 HEARINGS
80.10 DECISIONS AND NOTICES
80.11 JUDICIAL REVIEW
80.12 EFFECT ON OTHER REGULATIONS; FORMS AND INSTRUCTIONS
80.13 DEFINITION

ADDENDUM III

NOTICE TO EOHHS' CONTRACTORS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH EOHHS ARE SUBJECT TO THE PROVISIONS OF SECTION 504 OF THE REHABILITATION ACT OF 1973 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH ARE LOCATED AT 45 CFR, PART 84 HERINAFTER COLLECTIVELY REFERRED TO AS SECTION 504. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE THE PROVIDER'S ASSURANCE THAT IT WILL COMPLY WITH SECTION 504 OF THE REGULATIONS, WHICH PROHIBITS DISCRIMINATION AGAINST HANDICAPPED PERSONS IN PROVIDING HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS.

THE CONTRACTOR WILL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH SECTION 504. AN ELECTRONIC COPY OF THE CONTRACTOR'S WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

- THE CONTRACOR'S WRITTEN COMPLIANCE PLAN MUST ADDRESS THE FOLLOWING REQUIREMENTS:

- WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL SECTION 504 STANDARDS.

- DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE CONTRACTOR'S SENIOR MANAGEMENT.

- EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.

- ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.

- PROVISION FOR INTERNAL MONITORING AND AUDITING.

- WRITTEN COMPLAINT PROCEDURES

- PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.

- PROVISION THAT ALL CONTRACTORS, SUB-CONTRACTORS AND VENDORS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID CONTRACTORS, SUB-CONTRACTORS AND VENDORS ARE IN COMPLAINCE WITH SECTION 504.

THE CONTRACTOR MUST ENTER INTO AN AGREEMENT WITH EACH CONTRACTOR, SUB-CONTRACTOR OR VENDOR UNDER WHICH THERE IS THE PROVISION TO FURNISH TO THE CONTRACTOR, DHHS, DHS OR TO EOHHS ON REQUEST FULL AND COMPLETE INFORMATION RELATED TO SECTION 504 COMPLIANCE.

THE SERVICE PROVIDER MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAYS OF THE DATE OF A REQUEST BY DHHS, EOHHS OR DHS, FULL AND COMPLETE INFORMATION ON SECTION 504 COMPLAINCE BY THE SERVICE PROVIDER AND/OR ANY CONTRACTOR, SUB-CONTRACTOR OR VENDOR OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH SERVICE PROVIDER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE SECTION 504 REGULATIONS. A COPY OF THE REGULATIONS, TOGETHER WITH AN AUGUST 14, 1978 POLICY INTERPRETATION OF GENERAL INTEREST TO PROVIDERS OF HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS, IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, **RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES,** 57 HOWARD AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER (401) 462-2130.

CONTRACTORS SHOULD PAY PARTICULAR ATTENTION TO SUBPARTS A, B, C, AND F OF THE REGULATIONS WHICH PERTAIN TO THE FOLLOWING:

SUBPART A - GENERAL PROVISIONS

SECTION:

84.1	PURPOSE
84.2	APPLICATIONS
84.3	DEFINITIONS
84.4	DISCRIMINATION PROHIBITED
84.5	ASSURANCE REQUIRED
84.6	REMEDIAL ACTION, VOLUNTARY ACTION, AND SELF-EVALUATION

SUBPART B - EMPLOYMENT PRACTICES

SECTION:

SUBPART C - PROGRAM ACCESSIBILITY

SECTION:

SUBPART F - HEALTH, WELFARE, AND SOCIAL SERVICES

SECTION:

ADDENDUM IV

DRUG-FREE WORKPLACE POLICY

DRUG USE AND ABUSE AT THE WORKPLACE OR WHILE ON DUTY ARE SUBJECTS OF IMMEDIATE CONCERN IN OUR SOCIETY. THESE PROBLEMS ARE EXTREMELY COMPLEX AND ONES FOR WHICH THERE ARE NO EASY SOLUTIONS. FROM A SAFETY PERSPECTIVE, THE USERS OF DRUGS MAY IMPAIR THE WELL-BEING OF ALL EMPLOYEES, THE PUBLIC AT LARGE, AND RESULT IN DAMAGE TO PROPERTY. THEREFORE, IT IS THE POLICY OF THE STATE THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE IS PROHIBITED IN THE WORKPLACE. ANY EMPLOYEE(S) VIOLATING THIS POLICY WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. AN EMPLOYEE MAY ALSO BE DISCHARGED OR OTHERWISE DISCIPLINED FOR A CONVICTION INVOLVING ILLICIT DRUG BEHAVIOR, REGARDLESS OF WHETHER THE EMPLOYEES CONDUCT WAS DETECTED WITHIN EMPLOYMENT HOURS OR WHETHER HIS/HER ACTIONS WERE CONNECTED IN ANY WAY WITH HIS OR HER EMPLOYMENT. THE SPECIFICS OF THIS POLICY ARE AS FOLLOWS:

1. ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.

2. THE TERM "CONTROLLED SUBSTANCE" MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.

3. EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.

4. THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH

CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

5. IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.

6. THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.

7. THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

EMPLOYEE RETAIN THIS COPY

ADDENDUM V

DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE

I, Jean Yang, **CHIEF EXECUTIVE OFFICER, TUFTS HEALTH PUBLIC PLANS**, A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATE'S POLICY REGARDING THE MAINTENANCE OF A **DRUG-FREE WORKPLACE**. I HAVE BEEN INFORMED THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE DEFINED IN ADDENDUM IV (TO INCLUDE BUT NOT LIMITED TO SUCH DRUGS AS MARIJUANA, HEROIN, COCAINE, PCP, AND CRACK, AND SUCH DRUGS AS IDENTIFIED IN ADDENDUM IV AND MAY ALSO INCLUDE LEGAL DRUGS WHICH MAY BE PRESCRIBED BY A LICENSED PHYSICIAN IF THEY ARE ABUSED), IS PROHIBITED ON THE STATE'S PREMISES OR WHILE CONDUCTING STATE BUSINESS. I ACKNOWLEDGE THAT MY EMPLOYEES MUST REPORT FOR WORK IN A FIT CONDITION TO PERFORM THEIR DUTIES.

AS A CONDITION FOR CONTRACTING WITH THE STATE, AS A RESULT OF THE FEDERAL OMNIBUS DRUG ACT, I WILL REQUIRE MY EMPLOYEES TO ABIDE BY THE STATE'S POLICY. FURTHER, I RECOGNIZE THAT ANY VIOLATION OF THIS POLICY MAY RESULT IN TERMINATION OF THE CONTRACT.

SIGNATURE: Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:23:37 -05'00'

TITLE: President, Public Plans

DATE: February 28, 2022

ADDENDUM VI

SUBCONTRACTOR COMPLIANCE

I, Jean Yang, **CHIEF EXECUTIVE OFFICER, TUFTS HEALTH PUBLIC PLANS**, A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY CERTIFY THAT ALL APPROVED SUBCONTRACTORS PERFORMING SERVICES UNDER THE TERMS OF THIS AGREEMENT WILL HAVE EXECUTED WRITTEN CONTRACTS WITH THIS AGENCY, AND ALL CONTRACTS WILL BE MAINTAINED ON FILE AND PRODUCED UPON REQUEST. ALL CONTRACTS MUST CONTAIN LANGUAGE IDENTICAL TO THE PROVISIONS OF THIS AGREEMENT AS FOLLOWS:

SECTION 3.05.07	HOLD HARMLESS
SECTION 3.05.08	INSURANCE REQUIREMENT
SECTION 3.06.01	EMPLOYMENT PRACTICES
ADDENDUM II	NOTICE TO RI'S EXECUTIVE OFFICE OF HEATLH AND HUMAN SERVICES'/RHODE ISLAND DEPARTMENT OF HUMAN SERVICES NOTICE TO DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITY UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964
ADDENDUM III	NOTICE TO RI'S EXECUTIVE OFFICE OF HEATLH AND HUMAN SERVICES' /RHODE ISLAND DEPARTMENT OF HUMAN SERVICES NOTICE OF THE DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITY UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973

Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:24:29 -05'00'

AUTHORIZED AGENT/PROVIDER SIGNATURE

February 28, 2022

DATE

ADDENDUM VII

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

PUBLIC LAW 103-227, PART C - ENVIRONMENTAL TOBACCO SMOKE, ALSO KNOWN AS THE PRO-CHILDREN ACT OF 1994 **(ACT),** REQUIRES THAT SMOKING NOT BE PERMITTED IN ANY PORTION OF ANY INDOOR FACILITY OWNED OR LEASED OR CONTRACTED FOR BY AN ENTITY AND USED ROUTINELY OR REGULARLY FOR THE PROVISION OF HEALTH, DAY CARE, EDUCATION, OR LIBRARY SERVICES TO CHILDREN UNDER THE AGE OF 18, IF THE SERVICES ARE FUNDED BY FEDERAL PROGRAMS EITHER DIRECTLY OR THROUGH STATE OR LOCAL GOVERNMENTS, BY FEDERAL GRANT, CONTRACT, LOAN, OR LOAN GUARANTEE. THE LAW DOES NOT APPLY TO CHILDREN'S SERVICES PROVIDED IN PRIVATE RESIDENCES, FACILITIES FUNDED SOLELY BY MEDICARE OR MEDICAID FUNDS, AND PORTIONS OF FACILITIES USED FOR INPATIENT DRUG OR ALCOHOL TREATMENT. FAILURE TO COMPLY WITH THE PROVISIONS OF THE LAW MAY RESULT IN THE IMPOSITION OF A CIVIL MONETARY PENALTY OF UP TO $1000 PER DAY AND/OR THE IMPOSITION OF AN ADMINISTRATIVE COMPLIANCE ORDER ON THE RESPONSIBLE ENTITY.

BY SIGNING AND SUBMITTING THIS APPLICATION THE APPLICANT/GRANTEE CERTIFIES THAT IT WILL COMPLY WITH THE REQUIREMENTS OF THE **ACT.** THE APPLICANT/GRANTEE FURTHER AGREES THAT IT WILL REQUIRE THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN ANY SUBAWARDS WHICH CONTAIN PROVISIONS FOR CHILDREN'S SERVICES AND THAT ALL SUBGRANTEES WILL CERTIFY ACCORDINGLY.

Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:25:00 -05'00'

AUTHORIZED AGENT/PROVIDER SIGNATURE

February 28, 2022

DATE

ADDENDUM VIII

INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS

BY SIGNING AND SUBMITTING THIS CONTRACT, THE PROSPECTIVE PRIMARY PARTICIPANT IS PROVIDING THE CERTIFICATION SET OUT BELOW.

THE INABILITY OF A PERSON TO PROVIDE THE CERTIFICATION REQUIRED BELOW WILL NOT NECESSARILY RESULT IN DENIAL OF PARTICIPATION IN THIS COVERED TRANSACTION. IF NECESSARY, THE PROSPECTIVE PARTICIPANT WILL SUBMIT AN EXPLANATION OF WHY IT CANNOT PROVIDE THE CERTIFICATION. THE CERTIFICATION OR EXPLANATION WILL BE CONSIDERED IN CONNECTION WITH THE DEPARTMENT'S DETERMINATION WHETHER TO ENTER INTO THIS TRANSACTION. HOWEVER, FAILURE OF THE PROSPECTIVE PRIMARY PARTICIPANT TO FURNISH A CERTIFICATION OR EXPLANATION WILL DISQUALIFY SUCH PERSON FROM PARTICIPATION IN THIS TRANSACTION.

THE CERTIFICATION IN THIS ADDENDUM IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THE DEPARTMENT DETERMINED THAT THE PROSPECTIVE PRIMARY PARTICIPANT KNOWINGLY RENDERED AN ERRONEOUS CERTIFICATION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE DEPARTMENT. THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OR DEFAULT.

THE PROSPECTIVE PRIMARY PARTICIPANT WILL PROVIDE IMMEDIATE WRITTEN NOTICE TO THE DEPARTMENT IF AT ANY TIME THE PROSPECTIVE PRIMARY PARTICIPANT LEARNS THAT ITS CERTIFICATION WAS ERRONEOUS WHEN SUBMITTED OR HAS BECOME ERRONEOUS BY REASON OF CHANGED CIRCUMSTANCES.

THE TERMS "COVERED TRANSACTION," "DEBARRED," "SUSPENDED," "INELIGIBLE," "LOWER TIER COVERED TRANSACTION," "PARTICIPANT," "PERSON," "PRIMARY COVERED TRANSACTION," "PRINCIPAL," "PROPOSAL," AND "VOLUNTARILY EXCLUDED," AS USED IN THIS CLAUSE, HAVE THE MEANINGS SET OUT IN THE DEFINITIONS AND COVERAGE SECTIONS OF THE RULES IMPLEMENTING EXECUTIVE ORDER 12549: 45 CFR PART 76.

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS CONTRACT THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT WILL NOT KNOWINGLY ENTER INTO ANY LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE EXECUTIVE OFFICE.

THE PROSPECTIVE PRIMARY PARTICIPANT FURTHER AGREES BY SUBMITTING

THIS CONTRACT THAT IT WILL INCLUDE THE CLAUSE TITLED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS, PROVIDED BY EOHHS, WITHOUT MODIFICATION, IN ALL LOWER TIER COVERED TRANSACTIONS AND IN ALL SOLICITATIONS FOR LOWER TIER COVERED TRANSACTIONS.

A PARTICIPANT IN A COVERED TRANSACTION MAY RELY UPON A CERTIFICATION OF A PROSPECTIVE PARTICIPANT IN A LOWER TIER COVERED TRANSACTION THAT IS NOT DEBARRED, SUSPENDED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM THE COVERED TRANSACTION, UNLESS IT KNOWS THAT THE CERTIFICATION IS ERRONEOUS. A PARTICIPANT MAY DECIDE THE METHOD AND FREQUENCY BY WHICH IT DETERMINES THE ELIGIBILITY OF ITS PRINCIPALS. EACH PARTICIPANT MAY, BUT IS NOT REQUIRED TO, CHECK THE NONPROCUREMENT LIST (OF EXCLUDED PARTIES).

NOTHING CONTAINED IN THE FOREGOING WILL BE CONSTRUED TO REQUIRE ESTABLISHMENT OF A SYSTEM OF RECORDS IN ORDER TO RENDER IN GOOD FAITH THE CERTIFICATION REQUIRED BY THIS CLAUSE. THE KNOWLEDGE AND INFORMATION OF A PARTICIPANT IS NOT REQUIRED TO EXCEED THAT WHICH IS NORMALLY POSSESSED BY A PRUDENT PERSON IN THE ORDINARY COURSE OF BUSINESS DEALINGS.

EXCEPT FOR TRANSACTIONS AUTHORIZED UNDER PARAGRAPH 6 OF THESE INSTRUCTIONS, IF A PARTICIPANT IN A COVERED TRANSACTION KNOWINGLY ENTERS INTO A LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS SUSPENDED, DEBARRED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS TRANSACTION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE FEDERAL GOVERNMENT, THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OF DEFAULT.

ADDENDUM IX

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS

THE CONTRACTOR, AS THE PRIMARY PARTICIPANT, CERTIFIES TO THE BEST OF THE CONTRACTOR'S KNOWLEDGE AND BELIEF, THAT THE CONTRACTOR AND ITS PRINCIPALS:

1. ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;

2. HAVE NOT WITHIN A THREE (3) YEAR PERIOD PRECEDING THIS CONTRACT BEEN CONVICTED OF OR HAD A CIVIL JUDGMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST STATUES OR COMMISSION OF EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, OR RECEIVING STOLEN PROPERTY;

3. ARE NOT PRESENTLY INDICTED OR OTHERWISE CRIMINALLY OR CIVILLY CHARGED BY A GOVERNMENTAL ENTITY (FEDERAL, STATE OR LOCAL) WITH COMMISSION OF ANY OF THE OFFENSES ENUMERATED IN PARAGRAPH (1) AND (2) OF THIS ADDENDUM; AND

4. HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS CONTRACT HAD ONE OR MORE PUBLIC TRANSACTIONS (FEDERAL, STATE OR LOCAL) TERMINATED FOR CAUSE OR DEFAULT.

WHERE THE PROSPECTIVE PRIMARY PARTICIPANT IS UNABLE TO CERTIFY TO ANY OF THE STATEMENTS IN THIS CERTIFICATION, SUCH PROSPECTIVE PRIMARY PARTICIPANT WILL ATTACH AN EXPLANATION TO THIS CONTRACT.

Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:25:38 -05'00'

AUTHORIZED AGENT/PROVIDERSIGNATURE

February 28, 2022

DATE

ADDENDUM X

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS, AND COOPERATIVE AGREEMENTS

THE UNDERSIGNED CERTIFIES, TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, THAT:

1. NO FEDERAL APPROPRIATED FUNDS HAVE BEEN PAID OR WILL BE PAID, BY OR ON BEHALF OF THE UNDERSIGNED, TO ANY PERSON FOR INFLUENCING OR ATTEMPTING TO INFLUENCE AN OFFICER OR EMPLOYEE OF AN AGENCY, A MEMBER OF CONGRESS, AN OFFICER OR EMPLOYEE OF CONGRESS, OR AN EMPLOYEE OF A MEMBER OF CONGRESS IN CONNECTION WITH THE AWARDING OF ANY FEDERAL CONTRACT, THE MAKING OF ANY FEDERAL GRANT, THE MAKING OF ANY FEDERAL LOAN, THE ENTERING INTO OF ANY COOPERATIVE AGREEMENT, AND THE EXTENSION, CONTINUATION, RENEWAL, AMENDMENT, OR MODIFICATION OF ANY FEDERAL CONTRACT, GRANT, LOAN OR COOPERATIVE AGREEMENT.

2. IF ANY FUNDS OTHER THAN FEDERAL APPROPRIATED FUNDS HAVE BEEN PAID OR WILL BE PAID TO ANY PERSON FOR INFLUENCING OR ATTEMPTING TO INFLUENCE AN OFFICER OR EMPLOYEE OF ANY AGENCY, A MEMBER OF CONGRESS, AN OFFICER OF EMPLOYEE OF CONGRESS, OR AN EMPLOYEE OF A MEMBER OF CONGRESS IN CONNECTION WITH THIS FEDERAL CONTRACT, GRANT, LOAN, OR COOPERATIVE AGREEMENT, THE UNDERSIGNED WILL COMPLETE AND SUBMIT STANDARD FORM-LLL, A DISCLOSURE FORM TO REPORT LOBBYING IN ACCORDANCE WITH ITS INSTRUCTIONS.

3. THE UNDERSIGNED WILL REQUIRE THAT THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN THE AWARD DOCUMENTS FOR ALL SUBAWARDS AT ALL TIERS (INCLUDING SUBCONTRACTS, SUBGRANTS, AND CONTRACTS UNDER GRANTS, LOANS AND COOPERATIVE AGREEMENTS) AND THAT ALL SUBRECIPIENTS WILL CERTIFY AND DISCLOSE ACCORDINGLY.

THIS CERTIFICATION IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THIS TRANSACTION WAS MADE OR ENTERED INTO. SUBMISSION OF THIS CERTIFICATION IS A PREREQUISITE FOR MAKING OR ENTERING INTO THIS TRANSACTION IMPOSED BY SECTION 1352, TITLE 31, UNITED STATES CODE; AND THE FINAL IMPLEMENTING REGULATIONS PUBLISHED IN THE FEDERAL REGISTER, FEBRUARY 26, 1990, VOLUME 55, NO. 38, PAGES 6735-6756,

ENTITLED NEW RESTRICTIONS ON LOBBYING; INTERIM FINAL RULE. ANY PERSON WHO FAILS TO FILE THE REQUIRED CERTIFICATION WILL BE SUBJECT TO A CIVIL PENALTY OF NOT LESS THAN $10,000 AND NOT MORE THAN $100,000 FOR EACH SUCH FAILURE.

IF ANY NON-FEDERAL OR STATE FUNDS HAVE BEEN OR WILL BE PAID TO ANY PERSON IN CONNECTION WITH ANY OF THE COVERED ACTIONS IN THIS PROVISION, THE CONTRACTOR WILL COMPLETE AND SUBMIT A "DISCLOSURE OF LOBBYING ACTIVITIES" FORM.

THE CONTRACTOR MUST CERTIFY COMPLIANCE WITH ALL TERMS OF THE BYRD ANTI-LOBBYING AMENDEMENT (31 U.S.C 1352) AS PUBLISHED IN THE FEDERAL REGISTER MAY 27, 2003, VOLUME 68, NUMBER 101.

THE CONTRACTOR HEREBY CERTIFIES THAT IT WILL COMPLY WITH BYRD ANTI-LOBBYING AMENDMENT PROVISIONS AS DEFINED IN 45 CFR PART 93 AND AS AMENDED FROM TIME TO TIME.

FINAL RULE REQUIREMENTS CAN BE FOUND AT:

http://www.socialsecurity.gov/oag/grants/20cfr438.pdf
https://www.socialsecurity.gov/OP_Home/cfr20/435/435-ap01.htm

SIGNATURE: Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:26:13 -05'00'

TITLE: President, Public Plans

DATE: February 28, 2022

ADDENDUM XI

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS SUPPLEMENTAL TERMS AND CONDITIONS FOR CONTRACTS AND SUBAWARDS FUNDED IN WHOLE OR IN PART BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, PUB. L. NO. 111-5

1. Definitions

a. "ARRA" or "Recovery Act" means the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat.115.

b. "ARRA Funds" means any funds that are expended or obligated from appropriations made under ARRA.

c. "ARRA Requirements" means these Supplemental Terms and Conditions, as well as any terms and conditions required by: ARRA; federal law, regulation, policy or guidance; the federal Office of Management and Budget (OMB); the awarding federal agency; or, the Rhode Island Office of Economic Recovery and Reinvestment (OERR).

d. "Contract" means the contract to which these Supplemental Terms and Conditions are attached, and includes an agreement made pursuant to a grant or loan sub award to a Sub-Recipient.

e. "Contractor" means the party or parties to the Contract other than the Prime Recipient and includes a sub grantee or a borrower. For the purposes of ARRA reporting, The Contractor is either a Sub-Recipient or a Recipient Vendor under this Contract.

f. "Prime Recipient" means a non-Federal entity that expends Federal awards received directly from a Federal awarding agency to carry out a Federal program.

g. "Recipient Vendor" means a Vendor that receives ARRA Funds from a Prime Recipient.

h. "Subcontractor" means any entity engaged by the Contractor to provide goods or perform services in connection with this contract.

i. "Sub-Recipient Vendor" means a Vendor that receives ARRA Funds from a Sub-Recipient.

j. "Sub-Recipient" means a non-Federal entity receiving ARRA Funds through a Prime Recipient to carry out an ARRA funded program or project but does not include an individual that is a beneficiary of such a program. The term "Sub-Recipient" is intended to be consistent with the definition in OMB Circular A-133 and section 2.2 of the June 22, 2009 OMB Reporting Guidance.1 A Sub-Recipient is sometimes referred to as a sub grantee.

k. "Supplemental Terms and Conditions" means these Supplemental Terms and Conditions for Contracts and Sub Awards Funded in Whole or in Part by The American Reinvestment Recovery Act of 2009, Pub. L. No. 111-5, as may be subsequently revised pursuant to ongoing guidance from the relevant federal or State authorities.

l. "Vendor" means a dealer, distributor, merchant, or other seller providing goods or services that are required for the project or program funded by ARRA. The term "Vendor" is intended to be consistent with the definition in OMB Circular A-133 and section 2.2 of the June 22, 2009 OMB Reporting Guidance. Implementing Guidance for the Reports on Use of Funds Pursuant to the American Recovery and Reinvestment Act of 2009, M-09-21 (June 22, 2009), available at http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-21.pdf.

2. General

a. To the extent this Contract involves the use of ARRA Funds, the Contractor will comply with both the ARRA Requirements and these Supplemental Terms and Conditions, except where such compliance is exempted or prohibited by law.

b. The Contractor acknowledges these Supplemental Terms and Conditions may require changes due to future revisions of or additions to the ARRA requirements, and agrees that any revisions of or additions to the ARRA requirements will automatically become a part of the Supplemental Terms and Conditions without the necessity of either party executing or issuing any further instrument and will become a part of the Contractor's obligations under the Contract. The State of Rhode Island may provide written notification to the Contractor of such revisions, but such notice will not be a condition precedent to the effectiveness of such revisions.

3. Conflicting Terms

The Contractor agrees that, to the extent that any term or condition herein conflicts with one or more ARRA Requirements, the ARRA Requirements will control.

4. Enforceability

The Contractor agrees that if it or one of its subcontractors or sub-recipients fails to comply with all applicable federal and State requirements governing the use of ARRA funds, including any one of the terms and conditions specified herein, the State may withhold or suspend, in whole or in part, funds awarded under the program, recover misspent funds, or both. This provision is in addition to all other civil and criminal remedies available to the State under applicable state and federal laws and regulations.

5. Applicability to Subcontracts and Sub awards

The Contractor agrees that it will include the Supplemental Terms and Conditions set forth herein, including this provision, in all subcontracts or sub awards made in connection with projects funded in whole or in part by ARRA, and also agrees that it will not include provisions in any such

subcontracts or sub awards that conflict with either ARRA or the terms and conditions herein.

6. Availability of Funding

The Contractor understands that federal funds made available by ARRA are temporary in nature and agrees that the State is under no obligation to provide additional State financed appropriations once the temporary federal funds are expended.

7. Inspection and Audit of Records

The Contractor agrees that it will permit the State and its representatives, the United States Comptroller General or his representative or the appropriate inspector general appointed under section 3 or 8G of the Inspector General Act of 1978 or his representative to:

i. Examine, inspect, copy, review or audit any records relevant to, and/or involve transactions relating to, this agreement, including documents and electronically stored information in its or any of its subcontractors' or sub recipients' possession, custody or control unless subject to a valid claim of privilege or otherwise legally protected from disclosure; and

ii. Interview any officer or employee of the Contractor regarding the activities and programs funded by ARRA.

8. Registration Requirements

a. **DUNS Number Registration**. The Contractor agrees: (i) if it does not have a Dun and Bradstreet Data Universal Numbering System (DUNS) Number, to register for a DUNS Number within 10 business days of receiving this Contract; (ii) to provide the State with its DUNS number prior to accepting funds under this agreement; and (iii) to inform the State of any material changes concerning its DUNS number.

b. **Central Contractor Registration**. To the extent that the Contractor is a Sub-Recipient, it agrees: (i) to maintain a current registration in the Central Contractor Registration (CCR) at all times this agreement is in force, (ii) to provide the State with documentation sufficient to demonstrate that it has a current CCR registration, and (iii) to inform the State of any material changes concerning this registration.

c. **FederalReporting.gov Registration**. To the extent that the Contractor is a Sub - Recipient, it agrees: (i) to register on FederalReporting.gov within 10 business days of receiving this sub award; (ii) to maintain a current registration on FederalReporting.gov at all times this agreement is in force; (iii) to provide the State with documentation sufficient to demonstrate that it has a current registration on FederalReporting.gov, and (iv) to inform the State of any material changes concerning this registration.

9. Reporting Requirements under § 1512 of ARRA

a. The Contractor agrees to provide the State with data sufficient to fulfill the State's ARRA reporting requirements within the timeframes established by State or federal law, regulation or policy, including but not limited to section 1512 reporting requirements.

b. To the extent that the Contractor is a Sub-Recipient with a Sub award having a total value of greater than $25,000, it agrees to report directly to the Federal government the information described in section 1512(c) of ARRA using the reporting instructions and data elements available online at FederalReporting.gov and ensure that any information that is prefilled is corrected or updated as needed. Information from these reports will be made available to the public.

c. To the extent that the Contractor is a Sub-Recipient with a Sub award having a total value of greater than $25,000, it accepts delegation of reporting responsibility of FFATA data elements required under section 1512 of ARRA for payments from the State. Sub-Recipient will utilize the federal government's online reporting solution at www.FederalReporting.gov. Reports are due no later than ten calendar days after each calendar quarter in which the recipient receives the assistance award funded in whole or in part by ARRA.

d. To the extent that the Contractor is a Sub-Recipient with a Sub award having an initial total value of less than $25,000, but is subsequently modified to exceed $25,000, the Contractor agrees that subsections (b) and (c) above apply after the modification.

10. Buy American Requirements under § 1605 of ARRA

a. The Contractor agrees that, in accordance with section 1605 of ARRA, it will not use ARRA funds for a project for the construction, alternation, maintenance, or repair of a public building or public work unless all of the iron, steel and manufactured goods used in the project are produced in the United States in a manner consistent with United States obligations under international agreements. In addition to the foregoing, the Contractor agrees to abide by all regulations issued pursuant to section 1605 of ARRA.

b. The Contractor understands that this requirement may only be waived by the applicable federal agency in limited situations as set out in section 1605 of ARRA and federal regulations issued pursuant thereto.

11. Wage Rate Requirements under § 1606 of ARRA

a. The Contractor agrees that it will comply with the wage rate requirements contained in section 1606 of ARRA, which requires that, notwithstanding any other provision of law, all laborers and mechanics employed by contractors and subcontractors on projects funded directly by or assisted in whole or in part by and through the Federal Government pursuant to ARRA will be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the

Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40, United States Code. The Secretary of Labor's determination regarding the prevailing wages applicable in Rhode Island is available at http://www.gpo.gov/davisbacon/ri.html.

b. The Contractor agrees that it will comply with all federal regulations issued pursuant to section 1606 of ARRA, and that it will require any subcontractors or sub recipients to comply with the above provision.

12. Required Jobs Data Reporting under § 1512(c) (3) (D) of ARRA

a. The Contractor agrees, in accordance with section 1512(c)(3)(D) of ARRA and section 5 of the June 22, 2009 OMB Reporting Guidance (entitled "Reporting on Jobs Creation Estimates and by Recipients"), to provide an estimate of the number of jobs created and the number of jobs retained by ARRA-funded projects and activities. In order to perform the calculation, the Contractor will provide the data elements listed in sub-section (b) below.

b. The Contractor agrees that, no later than two business days after the end of each calendar quarter, it will provide to the State the following data elements using a form specified by the State:

   i. The total number of ARRA-funded hours worked on this award.

   ii. The number of hours in a full-time schedule for a quarter.

   iii. A narrative description of the employment impact of the ARRA funded work. This narrative is cumulative for each calendar quarter and at a minimum, will address the impact on the Contractor's workforce and the impact on the workforces of its subcontractors or sub-recipients.

c. The Contractor agrees that, in the event that the federal government permits direct reporting of section 1512(c)(3)(D) jobs data by sub-recipients or vendors, it will directly report jobs data to the federal government, consistent with any applicable federal law, regulations and guidance.

13. Segregation of Funds

a. The Contractor agrees that it will segregate obligations and expenditures of ARRA funds from other funding it receives from the State and other sources, including other Federal awards or grants.

b. The Contractor agrees that no part of funds made available under ARRA may be commingled with any other funds or used for a purpose other than that of making payments in support of projects and activities expressly authorized by ARRA.

14. Disclosure pursuant to the False Claims Act

The Contractor agrees that it will promptly refer to an appropriate Federal Inspector General any credible evidence that a principal, employee, agent, subcontractor or other person has committed a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving ARRA funds.

15. Disclosure of Fraud, Waste and Mismanagement to State Authorities

The Contractor will also refer promptly to the Rhode Island Department of Administration, Department of Purchases, any credible evidence that a principal, employee, agent, contractor, sub grantee, subcontractor, or other person has committed a criminal or civil violation of State or Federal laws and regulations in connection with funds appropriated under ARRA.

16. Prohibited Uses of ARRA Funds

a. The Contractor agrees that neither it nor any subcontractors or sub-recipients will use the funds made available under this agreement for any casinos or other gambling establishments, aquariums, zoos, golf courses, swimming pools, or similar projects.

b. The Contractor agrees that neither it nor any subcontractors or sub-recipients will use the funds made available under this agreement in a manner inconsistent with any certification made by the Governor or any other State official pursuant to the certification requirements of ARRA, which are published online at http://www.recovery.ri.gov/certification/.

17. Whistleblower Protection under §1553 of ARRA

a. The Contractor agrees that it will not discharge, demote, or otherwise discriminate against an employee as a reprisal for disclosures by the employee of information that he or she reasonably believes is evidence of (1) gross mismanagement of an agency contract or grant relating to covered funds; (2) a gross waste of covered funds; (3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; (4) an abuse of authority related to the implementation or use of covered funds; or (5) a violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) or grant, awarded or issued relating to covered funds.

b. The Contractor agrees to post notice of the rights and remedies available to employees under section 1553 of ARRA.

18. ARRA Protections for Indians in Medicaid and CHIP

Under section 5006(d), all contracts with Medicaid and CHIP managed care entities, which include

Medicaid and CHIP managed care organizations (MCOs) and PCCMs, must:

1. Permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;

2. Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;

3. Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either: (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

4. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45[xviii] and 42 CFR 447.46.

Please note that the State will strictly enforce compliance with all ARRA Requirements and these Supplemental Terms and Conditions. Accordingly, all Contractors should familiarize themselves with these Supplemental Terms and Conditions as well as all ARRA Requirements as they relate to this Contract.

ADDENDUM XII

BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Business Associate Agreement Addendum, (CONTRACTOR), (hereinafter referred to as "Business Associate"), may use, access or disclose Protected Health Information to perform functions, activities or services for or on behalf of the State of Rhode Island, (Executive Office of Health and Human Services, EOHHS) (hereinafter referred to as the "Covered Entity"), as specified herein and the attached Agreement between the Business Associate and the Covered Entity (hereinafter referred to as "the Agreement"), which this addendum supplements and is made part of, provided such use, access, or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d et seq., and its implementing regulations including, but not limited to, 45 CFR, parts 160, 162 and 164, hereinafter referred to as the Privacy and Security Rules and patient confidentiality regulations, and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (HITECH Act) and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates, Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26, and Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq. Business Associate recognizes and agrees it is obligated by law to meet the applicable provisions of the HITECH Act.

1. Definitions:

A. Generally:

(1) Terms used, but not otherwise defined, in this Agreement will have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 134.402, 164.410, 164.501 and 164.502.

(2) The following terms used in this Agreement will have the same meaning as those terms in the HIPAA, the Privacy and Security Rules and the HITECH Act: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

B. Specific:

(1) "Addendum" means this Business Associate Agreement Addendum.

(2) "Agreement" means the contractual Agreement by and between the State of Rhode Island, (EOHHS) and Business Associate, awarded pursuant to State of Rhode Island's Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and

Rhode Island Department of Administration, Division of Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

C. "Business Associate" generally has the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, will mean [Insert Name of Business Associate].

D. "Client/Patient" means Covered Entity funded person who is a recipient and/or the client or patient of the Business Associate.

E. "Covered Entity" generally has the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, will mean [Insert Name of Covered Entity].

F. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff.

G. "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media as defined in the HIPA Security Regulations.

H. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

I. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information including, the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

J. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations promulgated thereunder and as amended from time to time.

K. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under or pursuant to Section 13402 (h)(2) of the HITECH Act under ARRA.

L. "Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

M. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160 and 162, and Part 164, Subparts A and C. The application of Security provision Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations will apply to Business Associate of Covered Entity in the same manner that such sections apply to the Covered Entity.

N. "Suspected breach" is a suspected acquisition, access, use or disclosure of protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.

O. "Unsecured PHI" means PHI that is not secured, as defined in this section, through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

2. Obligations and Activities of Business Associate.

A. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as required by Law, provided such use or disclosure would also be permissible by law by Covered Entity.

B. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the "Security Rule."

C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

D. Business Associate agrees to report to Covered Entity by telephone call plus e-mail, web form, or fax the discovery of any use or disclosure of the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within one (1) hour and in no case later than forty-eight (48) hours of the breach and/or Security Incident.

E. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.

F. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

G. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate will notify Covered Entity upon receipt of such request.

H. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining compliance with the Privacy Rule and Security Rule.

I. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

J. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 §C.F.R. 164.528.

K. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it will, following the discovery of a breach of such information, notify Covered Entity by telephone call plus e-mail, web form, or fax upon the discovery of any breach of within one (1) hour and in no case later than forty-eight (48) hours after discovery of the breach and/or Security Incident. Such notice will include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a

description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.

L. To the extent the Business Associate is carrying out an obligation of the Covered Entity's under the Privacy Rule, the Business Associate must comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation.

M. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 45 C.F.R. §164.502(a)(5)(ii)(B)(2) applies.

N. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. §164.501, unless permitted by 45 C.F.R. §164.508(a)(3)(A)-(B).

O. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.

P. Business Associate hereby agrees to comply with state laws and rules and regulations applicable to PHI and personal information of individuals' information it receives from Covered Entity during the term of the Agreement.

i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law and rules and regulations; including, but not limited to: (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly; (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance; and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain a Written Information Security Program as required by any state law as applicable.

ii. The safeguards set forth in this Agreement will apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or

state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" will not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

3. Permitted Uses and Disclosures by Business Associate.

a. Except as otherwise limited to this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Service Arrangement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity required by 45 C.F.R. §164.514(d).

b. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504 (e)(2)(i)(B).

e. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

4. Obligations of Covered Entity

a. Covered Entity will notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. §164.520,

to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity will notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. Covered Entity will notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Permissible Requests by Covered Entity

Covered Entity will not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that, to the extent permitted by the Service Arrangement, Business Associate may use or disclose PHI for Business Associate's Data Aggregation activities or proper management and administrative activities.

6. Term and Termination.

a. The term of this Agreement will begin as of the effective date of the Service Arrangement and will terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.

b. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity will either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.

ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible.

c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, Business Associate will return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision will apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate will retain no copies of the PHI. Business Associate will ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.

d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate will provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Such written notice must be provided to the Covered Entity no later than sixty (60) days prior to the expiration of this Agreement. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate will extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. This provision regarding written notification will also apply to PHI that is in the possession of subcontractors or agents of Business Associate.

7. Miscellaneous.

a. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.

c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement will survive the termination of this Agreement.

d. Any ambiguity in this Agreement will be resolved to permit Covered Entity to comply with HIPAA and HITECH.

e. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

f. Nothing express or implied in this Agreement is intended to confer, nor will anything herein confer upon any person other than Covered Entity, Business

Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

g. Modification of the terms of this Agreement will not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.

h. This Agreement will be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

i. Should any provision of this Agreement be found unenforceable, it will be deemed severable and the balance of the Agreement will continue in full force and effect as if the unenforceable provision had never been made a part hereof.

j. This Agreement and the rights and obligations of the parties hereunder will in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.

k. All notices and communications required or permitted to be given hereunder will be sent by certified or regular mail, addressed to the other part as its respective address as shown on the signature page, or at such other address as such party will from time to time designate in writing to the other party, and will be effective from the date of mailing.

l. This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

m. Business Associate will maintain or cause to be maintained sufficient insurance coverage as will be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage will apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate will indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm,

or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision will survive termination of this Agreement.

8. ACKNOWLEDGMENT.

The undersigned affirms that he/she is a duly authorized representative of the Business Associate for which he/she is signing and has the authority to execute this Addendum on behalf of the Business Associate.

SIGNATURES ON NEXT PAGE

Acknowledged and agreed to by:

EOHHS:

Womazetta Jones Digitally signed by Womazetta Jones Date: 2022.03.02 16:25:59 -05'00'

AUTHORIZED AGENT

TITLE:

Womazetta Jones

Printed Name

3/2/2022

Date

TUFTS HEALTH PUBLIC PLANS:

Jean Yang Digitally signed by Jean Yang Date: 2022.02.28 12:27:03 -05'00'

AUTHORIZED AGENT

TITLE:

Jean Yang, President, Public Plans

Printed Name

February 28, 2022

Date

ATTACHMENT I TO BUSINESS ASSOCIATE AGREEMENT -

SOCIAL SECURITY DATA

This DUA requires that the REQUESTOR may not disclose Social Security Administration (SSA) provided data beyond the list of employees submitted to RI EOHHS and approved by EOHHS at the time of signing this DUA. Any additions or amendments to that list must be approved by EOHHS prior to sharing SSA data with additional employees. The REQUESTOR has been provided a copy of the Technical Security Requirements for the Electronic Exchange and Security of Information provided to State and Local Entities for the Exchange and Sharing of Information from the Social Security Information (hereinafter, the "TSSR"). The TSSR requirements are applicable to the REQUESTOR who receives verified SSA data and information obtained from EOHHS.

EOHHS requires that all contractors and REQUESTORS who process, handle, receive or transmit information provided to the state agency by SSA follow the terms of the EOHHS TSSR data exchange agreement with SSA. This is a requirement from SSA of EOHHS. EOHHS requires that the REQUESTOR and its agents receive SSA security awareness training as to the confidentiality and TSSR requirements for SSA verified data. The REQUESTOR shall maintain awareness-training records for their employees and require mandatory annual certification procedures which will be provided to EOHHS upon request. REQUESTOR shall ensure that users granted access to SSA-provided information receive adequate training on the sensitivity of the information, associated safeguards, operating procedures, and the civil and criminal consequences or penalties for misuse or improper disclosure.

EOHHS requires the REQUESTOR to certify to EOHHS that it conducts ongoing security compliance reviews that must meet SSA TSSR standards. EOHHS will conduct compliance reviews at least triennially commencing no later than three (3) years after the approved and executed DUA. Upon request, EOHHS will provide SSA with documentation of the EOHHS recurring compliance reviews of all contractors and agents.

The REQUESTOR agrees that it will ensure that SSA-provided information is not processed, maintained, transmitted, or stored in or by means of data communications channels, electronic devices, computers, or computer networks located in geographic or virtual areas not subject to U.S. law. Off-shore or overseas data access, transfer, transmittance, communication or sharing in any manner or method is not permitted under this agreement. Access to the SSA data received by this REQUESTOR is to authorized users who need the data to perform their official duties and shall be used on a need-to-know basis.

Cloud computing or cloud storage of SSA data is not permitted without explicit written permission from SSA's Chief Information Officer. This REQUESTOR must have formal Personally

Identifiable Information (PII) incident response procedures as defined under the HIPAA and HITECH Acts. The REQUESTOR must have technology controls sufficient to meet the TSSR requirements to prevent unauthorized retrieval of SSA-provided information by computer, remote terminal, or other means.

Onsite Reviews and Audits. At its discretion, EOHHS has the option to conduct onsite security reviews or make request of the REQUESTOR data recipient to ensure adequate security controls to safeguard the information EOHHSs provides to REQUESTOR. EOHHS may periodically review the REQUESTOR's system for employee access to determine if the same levels and types of access remain applicable as the date of the executed agreement.

The REQUESTOR will provide upon request to EOHHS a full audit trail of all persons who access, view, print or transfer SSA data in the format requested by EOHHS.
Access to the audit file must be restricted to authorized users with a "need to know," audit file data must be unalterable (read-only) and maintain for seven (7) years so that EOHHS may comply with its Records Retention requirements. Information in the audit file must be retrievable by an automated method and must allow EOHHS the capability to make the audit trail available to SSA upon request.

REQUESTOR acknowledges and agrees that the SSA, at its discretion, may request to include in the onsite compliance review an onsite inspection of the contractor's facility because the REQUESTOR will be using and accessing this SSA data off-site from EOHHS

PII loss is a reportable incident to EOHHS and must be reported to EOHHS within one hour but no later than twenty-four hours of a breach or a suspected breach. The term suspected breach is defined in the EOHHS Business Associate Agreement. PII means information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual. 2 CFR §200.79. A PII would include a partial SSA data number along with any other personally identifying information that is shared with or accessed by an unauthorized user.

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors: The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; The unauthorized person who used the protected health information or to whom the disclosure was made; Whether the protected health information was actually acquired or viewed; and The extent to which the risk to the protected health information has been mitigated.

REQUESTOR agrees to report to EOHHS a breach of SSA data or access of SSA data by an unauthorized user by telephone and e-mail the discovery of any use or disclosure of any SSA verified data provided to REQUESTOR by EOHHS under this Agreement, including breaches of unsecured SSA data and any security incident of which it becomes aware, within one (1) hour of the breach, suspected breach, and/or security incident.

Security Incident is defined as any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access or destroy information or misuse SSA data for a purpose outside of this agreement.

Before granting access to SSA-provided information, EOHHS will verify the identities of any REQUESTOR employees who will have access to SSA-provided information.

ADDENDUM XIII

REQUEST FOR PROPOSAL SCOPE OF WORK

Please see LOI document for bid proposal and scope of work.

ADDENDUM XIV

BUDGET

Medicaid benefit payments are processed through the MMIS system.
ATTACHMENT J identifies the capitation rates paid by EOHHS to the Contractor.

ADDENDUM XV

FEDERAL SUBAWARD REPORTING

PAYMENTS

IMPORTANT ITEMS TO NOTE ABOUT NEW REQUIREMENT

-- The Federal Funding Accountability and Transparency Act (FFATA or Transparency Act - P.L.109-282, as amended by section 6202(a) of P.L. 110-252) requires the Office of Management and Budget (OMB) to maintain a single, searchable website that contains current information on all Federal spending awards. That site is at www.USASpending.gov.

--Includes both mandatory and discretionary grants

--Do not include grants funded by the Recovery Act (ARRA)

--For more information about Federal Spending Transparency, refer to http://www.whitehouse.gov/omb/open

--If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award will be subject to the reporting requirements, as of the date the award exceeds $25,000

--If the initial award equals or exceeds $25,000 but funding is subsequently de-obligated such that the total award amount falls below $25,000, the award continues to be subject to the reporting requirements of the Transparency ACT and this Guidance.

ADDENDUM XVI

LIQUIDATED DAMAGES

THE PROSPECTIVE PRIMARY PARTICIPANT CONTRACTOR AGREES THAT TIME IS OF THE ESSENCE IN THE PERFORMANCE OF CERTAIN DESIGNATED PORTIONS OF THIS CONTRACT. THE EXECUTIVE OFFICE AND THE CONTRACTOR AGREE THAT IN THE EVENT OF A FAILURE TO MEET THE MILESTONES AND PROJECT DELIVERABLE DATES OR ANY STANDARD OF PERFORMANCE WITHIN THE TIME SET FORTH IN THE EXECUTIVE OFFICE'S BID PROPOSAL AND THE CONTRACTOR'S PROPOSAL RESPONSE (ADDENDUM XVI), DAMAGE WILL BE SUSTAINED BY THE EXECUTIVE OFFICE AND THAT IT MAY BE IMPRACTICAL AND EXTREMELY DIFFICULT TO ASCERTAIN AND DETERMINE THE ACTUAL DAMAGES WHICH THE EXECUTIVE OFFICE WILL SUSTAIN BY REASON OF SUCH FAILURE. IT IS THEREFORE AGREED THAT EXECUTIVE OFFICE, AT ITS SOLE OPTION, MAY REQUIRE THE CONTRACTOR TO PAY LIQUIDATED DAMAGES FOR SUCH FAILURES WITH THE FOLLOWING PROVISIONS:

1. WHERE THE FAILURE IS THE SOLE AND EXCLUSIVE FAULT OF THE EXECUTIVE OFFICE, NO LIQUIDATED DAMAGES WILL BE IMPOSED. TO THE EXTENT THAT EACH PARTY IS RESPONSIBLE FOR THE FAILURE, LIQUIDATED DAMAGES WILL BE REDUCED BY THE APPORTIONED SHARE OF SUCH RESPONSIBILITY.

2. FOR ANY FAILURE BY THE CONTRACTOR TO MEET ANY PERFORMANCE STANDARD, MILESTONE OR PROJECT DELIVERABLE, THE EXECUTIVE OFFICE MAY REQUIRE THE CONTRACTOR TO PAY LIQUIDATED DAMAGES IN THE AMOUNT(S) AND AS SET FORTH IN THE STATE'S GENERAL CONDITIONS OF PURCHASE AS DESCRIBED PARTICULARLY IN THE LOI, RFP, RFQ, OR SCOPE OF WORK, HOWEVER, ANY LIQUIDATED DAMAGES ASSESSED BY THE EXECUTIVE OFFICE WILL NOT EXCEED TEN PERCENT (10 %) OF THE TOTAL AMOUNT OF ANY SUCH MONTH'S INVOICE IN WHICH THE LIQUIDATED DAMAGES ARE ASSESSED AND WILL NOT IN THE AGGREGATE, OVER THE LIFE OF THE AGREEMENT, EXCEED THE TOTAL CONTRACT VALUE.

WRITTEN NOTIFICATION OF FAILURE TO MEET A PERFORMANCE REQUIREMENT WILL BE GIVEN BY THE EXECUTIVE OFFICE'S PROJECT OFFICER TO THE CONTRACTOR'S PROJECT OFFICER. THE CONTRACTOR WILL HAVE A REASONABLE PERIOD DESIGNATED BY THE EXECUTIVE OFFICE FROM THE DATE OF RECEIPT OF WRITTEN NOTIFICATION. IF THE FAILURE IS NOT MATERIALLY

RESOLVED WITHIN THIS PERIOD, LIQUIDATED DAMAGES MAY BE IMPOSED RETROACTIVELY TO THE DATE OF EXPECTED DELIVERY.

IN THE EVENT THAT LIQUIDATED DAMAGES HAVE BEEN IMPOSED AND RETAINED BY THE EXECUTIVE OFFICE, ANY SUCH DAMAGES WILL BE REFUNDED, PROVIDED THAT THE ENTIRE SYSTEM TAKEOVER HAS BEEN ACCOMPLISHED AND APPROVED BY THE EXECUTIVE OFFICE ACCORDING TO THE ORIGINAL SCHEDULE DETAILED IN THE CONTRACTOR'S PROPOSAL RESPONSE INCLUDED IN THIS CONTRACT (ADDENDUM XVI) AS MODIFIED BY MUTUALLY AGREED UPON CHANGE ORDERS.

TO THE EXTENT LIQUIDATED DAMAGES HAVE BEEN ASSESSED, SUCH DAMAGES WILL BE THE SOLE MONETARY REMEDY AVAILABLE TO THE EXECUTIVE OFFICE FOR SUCH FAILURE. THIS DOES NOT PRECLUDE THE STATE FROM TAKING OTHER LEGAL ACTION.

ADDENDUM XVII

EQUAL EMPLOYMENT OPPORTUNITY

DURING THE PERFORMANCE OF THIS AGREEMENT, THE CONTRACTOR AGREES AS FOLLOWS:

1. THE CONTRACTOR WILL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT FOR EMPLOYMENT RELATING TO THIS AGREEMENT BECAUSE OF RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY, UNLESS RELATED TO A BONA FIDE OCCUPATIONAL QUALIFICATION. THE CONTRACTOR WILL TAKE AFFIRMATIVE ACTION TO ENSURE THAT APPLICANTS ARE EMPLOYED AND EMPLOYEES ARE TREATED EQUALLY DURING EMPLOYMENT, WITHOUT REGARD TO THEIR RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, OR PHYSICAL OR MENTAL DISABILITY.

   SUCH ACTION WILL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING: EMPLOYMENT, UPGRADING, DEMOTIONS, OR TRANSFERS; RECRUITMENT OR RECRUITMENT ADVERTISING; LAYOFFS OR TERMINATIONS; RATES OF PAY OR OTHER FORMS OF COMPENSATION; AND SELECTION FOR TRAINING INCLUDING APPRENTICESHIP. THE CONTRACTOR AGREES TO POST IN CONSPICUOUS PLACES AVAILABLE TO EMPLOYEES AND APPLICANTS FOR EMPLOYMENT NOTICES SETTING FORTH THE PROVISIONS OF THIS NONDISCRIMINATION CLAUSE.

2. THE CONTRACTOR WILL, IN ALL SOLICITATIONS OR ADVERTISING FOR EMPLOYEES PLACED BY OR ON BEHALF OF THE CONTRACTOR RELATING TO THIS AGREEMENT, STATE THAT ALL QUALIFIED APPLICANTS WILL RECEIVE CONSIDERATION FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY.

3. THE CONTRACTOR WILL INFORM THE CONTRACTING EXECUTIVE OFFICE'S EQUAL EMPLOYMENT OPPORTUNITY COORDINATOR OF ANY DISCRIMINATION COMPLAINTS BROUGHT TO AN EXTERNAL REGULATORY BODY (RI ETHICS COMMISSION, RI DEPARTMENT OF ADMINISTRATION, US DHHS OFFICE OF CIVIL RIGHTS) AGAINST THEIR AGENCY BY ANY INDIVIDUAL AS WELL AS ANY LAWSUIT REGARDING ALLEGED DISCRIMINATORY PRACTICE.

4. THE CONTRACTOR WILL COMPLY WITH ALL ASPECTS OF THE AMERICANS WITH DISABILITIES ACT (ADA) IN EMPLOYMENT AND IN THE PROVISION OF SERVICE TO INCLUDE ACCESSIBILITY AND REASONABLE ACCOMMODATIONS FOR EMPLOYEES AND CLIENTS.

5. CONTRACTORS AND SUBCONTRACTORS WITH AGREEMENTS IN EXCESS OF $50,000 WILL ALSO PURSUE IN GOOD FAITH AFFIRMATIVE ACTION PROGRAMS.

6. THE CONTRACTOR WILL CAUSE THE FOREGOING PROVISIONS TO BE INSERTED IN ANY SUBCONTRACT FOR ANY WORK COVERED BY THIS AGREEMENT SO THAT SUCH PROVISIONS WILL BE BINDING UPON EACH SUBCONTRACTOR, PROVIDED THAT THE FOREGOING PROVISIONS WILL NOT APPLY TO CONTRACTS OR SUBCONTRACTS FOR STANDARD COMMERCIAL SUPPLIES OR RAW MATERIALS.

ADDENDUM XVIII

BID PROPOSAL

Please see supplemental Bid Proposal document.

ADDENDUM XIX

CORE STAFF

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

Services below are covered for all members based on medical necessity criteria. Contractor is responsible for ensuring access and quality of care to services listed in ATTACHMENT A. The Contractor will provide services which increase the member's opportunities to remain at home and out of an institutional setting. The Contractor is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health.

The Contractor will recognize that services in entitled "scope of benefits" are provided as examples and do not represent an all-inclusive list of benefits.

Some services are subject to stop loss provisions as defined in ATTACHMENT N, Special Terms & Conditions, Section 12 and 13.

SERVICE	**SCOPE OF BENEFIT (ANNUAL)** **Including but not limited to:**
Inpatient Hospital Care	As medically necessary. EOHHS will be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. The Contractor will be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from the Contractor's Health Plan and enrolled in another Health Plan or re- enrolled into Medicaid fee- for-service, until the management of the Member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.
Outpatient Hospital Services	Covered based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.
Physician/Provider Services	Covered based on medical necessity, including primary care, specialty care, obstetric and newborn care.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services. Covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription.
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.
Laboratory Services	Covered when ordered by a Health Plan physician/provider including urine drug screens.
Radiology Services	Covered when ordered by a Health Plan physician/provider.
Diagnostic Services	Covered when ordered by a Health Plan physician/provider.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Mental Health and Substance Use –Outpatient& Inpatient	Covered as needed for all members, as defined in ATTACHMENT O & ATTACHMENT P, including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations described in ATTACHMENT B. Also includes, DCYF ordered administratively necessary days (See Attachments O & P for further details), or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
EPSDT Services	Provided to all children, pregnant women, unborn children, and young adults up to age 21(described in greater detail in Section 2.06.01.058 and ATTACHMENT ED). Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services (2.10.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician/provider. All skilled and custodial care covered. For Rhody Health Partners/Expansion members, the Contractor payments are limited to thirty (30) consecutive days. The Contractor is responsible for notifying the State to begin dis-enrollment process.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e., a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. Condition of Probation: Treatment is prescribed as a condition of probation Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board. Exclusions are presented in ATTACHMENT B

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Court-ordered mental health and substance use treatment – civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re- assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-day prior authorization requirement for residential treatment as defined in SECTION 2.12.03.02.

SERVICE	SCOPE OF BENEFIT (ANNUAL) **Including but not limited to:**
Court Ordered Treatment for Children	All Court Ordered Treatment must be provided in totality as an in-plan benefit including treatments which are ordered by the court to be provided by a non-network provider. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires.
Podiatry Services	Covered as ordered by Health Plan physician/provider.
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	*Inpatient:* The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* The Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary. As detailed in the *Schedule of In-Plan Oral Health Benefits updated January 2017.*

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Hospice Services	Covered as ordered by a Health Plan physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by a Health Plan physician/provider as medically necessary.
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions as defined in ATTACHMENT DE and as referred by a Health Plan physician.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Plan physician.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible All types of case management encounters and communications (face-to-face, telephone contact, other) Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Early Intervention	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
Neonatal Intensive Care Unit (NICU)	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from non-W&I NICU with admission to W&I for continued care.
Health Homes for Children	• comprehensive care management; • care coordination; • referral to community and social support services (formal and informal); • individual and family support services; • comprehensive transitional care; and • health promotion
Complementary Alternative Medicine Services	Treatment from a chiropractor, acupuncturist, and massage therapist for the treatment of chronic pain as specified in section 2.06.01.11
Institutes for Mental Disease Exclusion for Substance Use Disorder treatment up to 30 Days	The Contractor must offer appropriate transitional care management to members upon discharge and coordinate and/or arrange for in-plan medically necessary services. The Contractor will ensure that members discharged from an IMD after 15 days receive appropriate clinical treatment in a non-IMD facility for as many days as medically necessary. Additionally, the Contractor will recognize cases in which member are subject to a court ordered length of stay longer than 15 days. The Contractor will ensure that the length of stay for members is in compliance with the court order. While EOHHS requires that Contractor comply with all State and Federal regulations, Contractor should exercise its judgement with regard to clinical decisions

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Doula Services	Covered when medically necessary. **Special Note**: EOHHS must obtain approval from CMS on the proposed SPA during this contract amendment period. Until EOHHS receives such SPA approval, Contractor should not pay for any Doula services, except if offered as a value-add program. Upon SPA approval, EOHHS will communicate to Contractors the retroactive effective date of the SPA and Contractor must pay Doula services that were provided from the SPA effective date onward.

"In lieu of services" are in-plan alternative services in a setting that is not included in the state plan or otherwise covered by the contract but are medically appropriate, cost-effective substitutes for state plan services included within a contract. EOHHS identifies the following services as those services which the Contractor may provide to members without obtaining prior approval from EOHHS. If the Contractor seeks to provide cost-effective alternative services not listed below, it must obtain prior written approval from EOHHS.

SERVICES APPROVED BY EOHHS AS IN LIEU OF SERVICES:	SERVICE FOR WHICH THE IN LIEU OF SERVICE IS OFFERED AS AN ALTERNATIVE:
• Chiropractic Services • Acupuncture • Massage Therapy • Yoga • Meditation classes for purpose of pain management	• Medications for treating pain. • Invasive procedures including surgical procedures.
• Medication management services which include: o Ensuring compliance with medication regime o Prepacking medication boxes o Creating reference guide describing medications and dosages.	• Extended Skilled Nursing Services.
• Nutritional Programs which include: o Weight Reduction Programs for Obesity o Therapeutic counseling o Group support programs.	• Gastric By-pass Surgery • Weight Reduction Medications prescribed by a licensed provider

SERVICES APPROVED BY EOHHS AS IN LIEU OF SERVICES:	SERVICE FOR WHICH THE IN LIEU OF SERVICE IS OFFERED AS AN ALTERNATIVE:
• Meals on Wheels-Meal delivery for persons who are in danger of malnutrition and/or have limited mobility or access to transportation.	• Preventive homecare services. • Homemaking services up to 6 hrs/wk.
• Home care hours greater than 6 hours to prevent increases in level of care or institutionalization	• Long Term Care placements
• Medically appropriate smart phone applications	• Face to Face MD office visit with a licensed provider
• Therapeutic Light Boxes	• Antidepressant medication management for seasonal depression

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

ATTACHMENT B: SCHEDULE OF OUT-OF-PLAN BENEFITS

These benefits are not included in the capitated benefit. The Contractor is expected to refer to and coordinate these services as appropriate. These services will be provided by existing Medicaid-approved providers who will be reimbursed directly by the State on a fee-for-service or contractual basis. These benefits are not available to the following categories of RIte Care Eligible: (1) SOBRA-extension group with income above two hundred fifty percent (250 %) of the FPL as described in Section Eligibility of Pregnant Women Under 250 Percent of the FPL ("SOBRA-Extension Group"), (2) those receiving Extended Family Planning benefits as described in Section 2.04.01.01.4, Eligibility of Extended Family Planning Group.

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Dental services Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans). Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult)
All Rhody Health Partners, RIte Care and Expansion members	Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in ATTACHMENT A Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children Centers of Excellence Programs

ATTACHMENT C

SCHEDULE OF NON-COVERED SERVICES

ATTACHMENT C

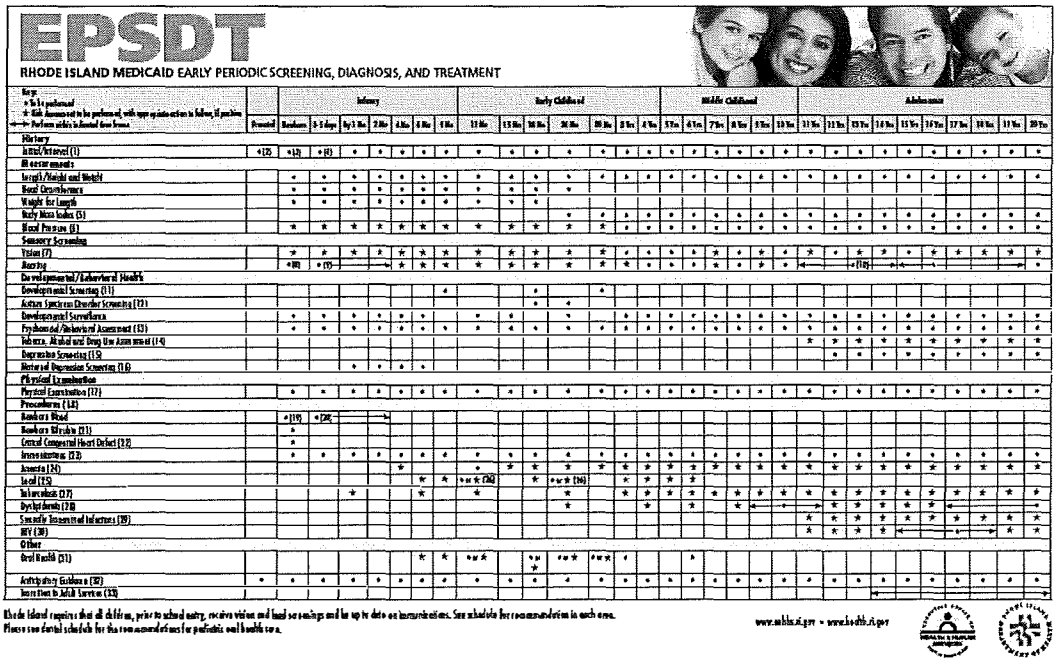
SCHEDULE OF NON-COVERED SERVICES

- Experimental Procedures
- Abortion except to preserve the life of the woman, or in cases of rape or incest
- Private rooms in hospitals (unless medically necessary)
- Cosmetic surgery
- Infertility Treatment Services
- Medications for sexual or erectile dysfunction

ATTACHMENT D

RHODE ISLAND EPSDT PERIODICITY SCHEDULE

RHODE ISLAND EPSDT PERIODICITY SCHEDULE



EPSDT

RHODE ISLAND MEDICAID EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

Key:
• To be performed
* Risk Assessment to be performed, with appropriate action as follows, if positive
←→ Perform within indicated time frame

	Prenatal	Infancy						Early Childhood							Middle Childhood						Adolescence								
		Newborn	3-5 days	By 1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	15 Mo	18 Mo	24 Mo	30 Mo	36 Mo	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
History																															
Initial/Interval (1)	•(2)	•(3)	•(4)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																															
Length/Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																			
Weight for Length		•	•	•	•	•	•	•	•	•	•																				
Body Mass Index (5)												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure (6)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sensory Screening																															
Vision (7)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hearing	•(8)	•(9)	←	→	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	←(10)→									
Developmental/Behavioral Health																															
Developmental Screening (11)							•			•		•			•																
Autism Spectrum Disorder Screening (12)										•	•																				
Developmental Surveillance		•	•	•	•	•	•		•	•		•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment (13)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol and Drug Use Assessment (14)																						•	•	•	•	•	•	•	•	•	•
Depression Screening (15)																						•	•	•	•	•	•	•	•	•	•
Maternal Depression Screening (16)				•	•	•	•																								
Physical Examination																															
Physical Examination (17)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures (18)																															
Newborn Blood		•(19)	•(20)	→																											
Newborn Bilirubin (21)		•																													
Critical Congenital Heart Defect (22)		•																													
Immunizations (23)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Anemia (24)						•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Lead (25)							•	•	• or • (26)		•	• or • (26)		•	•	•	•														
Tuberculosis (27)				•			•		•			•			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Dyslipidemia (28)												•			•		•		•			←	→	•	•	•	•	←		→	•
Sexually Transmitted Infections (29)																						•	•	•	•	•	•	•	•	•	•
HIV (30)																						•	•	•	•	←		→	•	•	•
Other																															
Oral Health (31)							•	•	• or •		• or •	• or •	• or •	•			•														
Anticipatory Guidance (32)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention (33)																												←			→

Rhode Island requires that all children, prior to school entry, receive vision and hearing screenings and be up to date on immunizations. See schedule for recommendations in each area.
Please see dental schedule for the recommendations for pediatric oral health care.

www.ohhs.ri.gov • www.bhddh.ri.gov

1 If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.

2 A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).

3 Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4 Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). ~~Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns"~~ (http://pediatrics.aappublications.org/content/125/2/405.full).

5 Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).

6 Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7 A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597), but is not currently EPSDT requirement due to cost of device.

8 Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).

9 Verify results as soon as possible, and follow up, as appropriate.

10 Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).

11 See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).

12 Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).

13 This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).

14 A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.

15 Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.

16 Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).

17 At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).

18 These may be modified, depending on entry point into schedule and individual need.

19 Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory ~~Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.~~ [illegible] follow-up is communicated to PCP by the RI Newborn Screening Program. For results or to confirm screening refer to KIDSNET or call the Program Coordinator at 401-222-7819.

20 Verify results as soon as possible, and follow up, as appropriate.

21 Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).

22 Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

23 Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.

24 See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).

25 For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf). RI State Law requires lead screening at a minimum between 9 and 15 months of age, and again 12 months later, between 21 and 36 months of age. See the Department of Health website at [illegible] for more detail.

26 Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

27 Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

28 See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

29 Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.

30 Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once ~~between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who~~ are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

31 Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and ~~refer to a dental home. [illegible]~~ ~~Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children"~~ (http://pediatrics.aappublications.org/content/134/6/1224). See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/dentalchild.htm). ~~Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use~~ are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626). If primary water source ~~is deficient in fluoride, consider oral fluoride supplementation. For those at risk, the PCP should start the application of fluoride varnish for caries prevention~~ (http://pediatrics.aappublications.org/content/134/3/626). See also guidance for health care providers at https://www.health.ri.gov/[illegible].

32 Anticipatory Guidance refers to age-appropriate guidance to parents, children, and adolescents on injury and illness prevention, developmental surveillance and milestones, sexuality, substance abuse, etc.

33 Transition refers to equipping the adolescent and family for the transfer from pediatric to adult health care by age 21. See the RI Department of Health website located at www.health.ri.gov for healthcare transition resources.

ATTACHMENT E

RHODE ISLAND NUTRITION STANDARDS

I. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) – for Adults

1. Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) is required pursuant to screening routinely completed as part of periodic health exams as defined below:

SCREENING	STANDARD FOR REFERRAL TO RD, LDN
Weight Status*:	
Underweight	BMI ≤18.5
Overweight	BMI 25 – 29.9
Obesity	BMI ≥ 30
Unintended, Clinically Significant Weight Loss	Weight Loss ≥ 10% of Normal Body Weight
Blood Pressure	Diastolic ≥ 80 mm Hg Systolic ≥ 130 mm Hg
Fasting Blood Lipids	Cholesterol > 200 mg/dl LDL > 130 mg/dl (for individuals with diabetes, LDL > 100 mg/dl) HDL < 40 mg/dl TG > 150 mg/dl
Blood Glucose: Diabetes	Diagnosis of diabetes; A1C ≥ 6.5
Pre-Diabetes	Pre-diabetes; A1C between ≥ 5.8 and <6.5

* Weight Status Assessed Using Body Mass Index (BMI)

1. Referral to a RD, LDN is required as a result of a diagnosis of chronic disease, which can be managed, controlled, or ameliorated through Medical Nutrition Therapy, such as:

DISEASE/ CONDITION
Cardiovascular Disease
Hypercholesterolemia
Dyslipidemia
Chronic Renal Disease
Pulmonary Disease
Gastrointestinal Disease
Diabetes
Pre-Diabetes
Obesity
Eating Disorders
Hypertension
Autoimmune Disease
Anemia
Liver Disease/Hepatitis
HIV Positive/AIDS
Severe chronic food allergies
Phenylketonuria
Muscular-Skeletal Disease

2. Referral to a RD, LDN is also required under the following circumstances:

   a. Prescription regimen that has proven impact on nutrient absorption utilization and metabolism, i.e. Dilantin, Phenobarbital, MAO inhibitors, Coumadin, etc.
   b. Other conditions as medically necessary.

II. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) - Pregnant Women

1. Referral to a RD, LDN is required pursuant to screening routinely completed as part of normal obstetric care as defined by ACOG and detailed below:

Recommended Screening	Standard for Referral to a RD, LDN
Medical History:	
Past Pregnancy	History of Low Birth Weight (≤2500 grams), SGA, and/or premature infant (≤ 37 weeks GA) Macrosomia or LGA (≥4000 grams) Short Interpregnancy Interval
Current Pregnancy	Cardiovascular Disease/Disorders Renal Disease Pulmonary Disease Gastrointestinal Disease/Disorders Endocrine Disorders: Diabetes Mellitus, Gestational Diabetes Chronic/Gestational Hypertension Hypertensive Disorders including Pre-eclampsia/ Eclampsia Hypo/Hyperthyroidism Autoimmune Disease Anemia Liver Disease including Hepatitis Cancer Seizure Disorders Intrauterine Growth Retardation Multiple Pregnancy HIV Positive or AIDS Metabolic Disease Including Maternal Phenylketonuria Hyperemesis Gravidarum
Weight and Height:	
Pregravid Underweight Pregravid Overweight Pregravid Obesity	BMI* < 18.5 BMI 25.0-29.9 BMI > 30
Insufficient Weight Gain	First Trimester: Any weight loss during first trimester; Weight gain ≤ 3-5 lbs. /month for Pregravid under /normal. ≤ 2 lbs./month in second half of pregnancy

Recommended Screening	Standard for Referral to a RD, LDN
Excessive Weight Gain	Third Trimester: Weight gain $\leq$ 3 lbs. /month (for Pregravid underweight $\leq$ 4 lbs. /month; for Pregravid overweight/obese $\leq$ 2 lbs. /month). Weight Gain $\geq$ 6.5 lbs./month
Blood Pressure	Diastolic $\geq$90 mm Hg Systolic $\geq$140 mm Hg
Hemoglobin	1st Trimester 2nd Trimester 3rd Trimester <11.0 <10.5 <11.0

* Pregravid Weight Status Assessed Using Body Mass Index (BMI) = Wt. in lbs. / (Hot in Inches)^2

Note: GA- Gestational Age; SGA- Small for Gestational Age; LGA- Large for Gestational Age.

2. Referral to a RD, LDN is required under the following circumstances:

a. Age: $\leq$ 17 years or $\geq$ 35 years
b. Chronic/ Acute Under nutrition: Eating disorders such as anorexia and/or bulimia; restrictive eating patterns cultural practices and/or unusual dietary practices; substance use.
c. Severe chronic food allergies.
d. Prescription drug regimen that has proven impact on nutrient absorption, utilization, and metabolism.
e. Other conditions as medically necessary.

III. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) - Children Age 0-21 Years

1. Referral to a RD, LDN is required pursuant to screening routinely completed as part of periodic health exams as defined by AAP and in the Guide to Clinical Preventive Services as detailed below:

SCREENING	STANDARD FOR REFERRAL TO A RD, LDN
HEIGHT AND WEIGHT	
Infants 0-12 Months:	Measure at all routine preventive visits.
Underweight	Weight for Length <25th percentile
Overweight	Weight for Length >85th percentile
Stunting	Length for Age <5th percentile or gross deviation from mid-parental height
Children 1-18 Years:	Measure bi-annually for children 1-2 years of age and annually for children 2-18 years of age.
Underweight	BMI <10th percentile
Overweight	BMI >85- 95th percentile
Obesity	BMI > 95th
Stunting	Length/Height for Age <5th percentile
Inappropriate Growth Pattern: Children 0 to 18 Years	Increase or decrease of more than 2 standard deviations (channels on growth chart) in established growth pattern.
Children 19-21:	
Underweight	BMI < 18.5
Overweight	BMI 25 – 29.9
Obesity	BMI ≥ 30
Hemoglobin: Screen at 6-9 months, 24 months, 8 years, and 18 years. More frequently when indicated.	Age Sex Hgb Level 6m-4 years both <11.0 g/dl 5-10 years both <11.5 g/dl 11-14 years both <12.0 g/dl 15-21 years females <12.0 g/dl 15-19 years males <13.0 g/dl 20-21 years males <13.5 g/dl
Lead Screening*	≥ 10 ug/dl

SCREENING	STANDARD FOR REFERRAL TO A RD, LDN
Hereditary or Metabolic Screening mandated by State Law: PKU, Galactosemia, etc. Blood Pressure Children 3-6 years old, screen annually Children 8-21 years old, screen every other year Serum Cholesterol**	Positive Test Results Age Years / Diastolic / Systolic MM Hg 3-5: 76 / 116 6-9: 78 / 122 10-12: 82 / 126 13-15: 86 / 136 Total Serum Cholesterol ≥170 mg/dl LDL ≥ 110 mg/dl

* See *Lead Screening & Referral Guidelines* on www.health.ri.gov under Lead Screening.

** Screen any child more than 2 years of age whose parent(s) or grandparent(s) have documented cardiovascular, peripheral vascular, cardiovascular disease before age 55 in males and before age 65 in females and/or a parent(s) have a total (fasting) serum cholesterol level ≥ 200 mg/dl

2. Referral to a RD, LDN is required as a result of diagnosis of chronic disease or condition, which can be managed, controlled, or ameliorated through therapeutic diet and nutrition counseling as detailed below:

DISEASE/ CONDITION
Cardiovascular Disease including Congenital Heart Disease
Cancer
Renal Disease
Pulmonary Disease, including Cystic Fibrosis
Gastrointestinal Disease
Diabetes
Pre-Diabetes
Overweight
Obesity
Hypertension
Liver Disease
HIV/AIDS
Metabolic Disorders including PKU

3. Referral to a RD, LDN is also required under the following circumstances:

    a. Special health care needs carrying multiple nutrition risks including birth defects, neuromuscular disorders, developmental delays, and severe feeding problems.

    b. Eating disorders such as anorexia and bulimia and cultural, unusual or bizarre eating practices that place child at medical or nutritional risk, i.e. PICA, diuretic or laxative use and/or self-induced vomiting to control weight, etc.

    c. Severe chronic food allergies.

    d. Prescription regimen that has proven impact on nutrient absorption, utilization, and metabolism.

    e. Other conditions as medically necessary.

ATTACHMENT F

EXTENDED FAMILY PLANNING PROGRAM

ATTACHMENT F

Extended Family Planning Program

1. **Eligibility Requirements.** Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only women, meeting the eligibility criteria below into the demonstration who have a family income at or below 253 percent of the FPL and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP).Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 253 percent of the FPL at the time of annual redetermination are auto enrolled in the Extended Family Planning group.

2. **Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

3. **Eligibility Redeterminations.** The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the State's option, redeterminations may be administrative in nature.

4. **Disenrollment from the Extended Family Planning Program.** If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program.

5. **Extended Family Planning Program Benefits.** Benefits for the family planning expansion group are limited to family planning and family planning-related services. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

   a. Approved methods of contraception;

   b. Sexually transmitted infection (STI) testing, Pap smears and pelvic exams;

      Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or

provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

c. Members covered to receive three hundred sixty-five (365) days of prescription contraception of F.D.A. approved drugs and devices which will require a prescription dispensed as a single prescription

d. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and

e. Contraceptive management, patient education, and counseling.

6. **Family Planning-Related Benefits.** Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

   a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

   b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

   c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

   d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

   e. Treatment of major complications (including anesthesia) arising from a family planning procedure such as:

      i. Treatment of a perforated uterus due to an intrauterine device insertion;
      i. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or

ii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

7. **Services.** Services provided through the Extended Family Planning program are paid either through a capitated managed care delivery system or fee for service (FFS).

ATTACHMENT G

FQHC AND RHC SERVICES

ATTACHMENT G

FQHC AND RHC SERVICES

CATEGORY OF SERVICE	COVERED SERVICES
Core Services as Defined in Section 1861 (Aa)(1)(A)-(C) of the Social Security Act	Physician services Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered) Pneumococcal vaccine and its administration and influenza vaccine and its administration Physician assistant services Nurse practitioner services Clinical psychologist services Clinical social work services Services and supplies incidental to clinical psychologist and clinical social worker services as would otherwise be covered if furnished by or incidental to physician services Part-time or intermittent nursing care and related medical supplies to a homebound individual (in the case of those FQHCs that are located in an area that has a shortage of home health agencies)

ATTACHMENT G

CATEGORY OF SERVICE	COVERED SERVICES
Additional FQHC Services	In addition to the above Core Services, FQHCs (as opposed to RHCs) are required to provide preventive primary health services under Sections 329, 330, and 340 of the Public Health Service Act and defined in Regulation 405.2448
Other Ambulatory Services	Any other Title XIX-payable ambulatory services offered by the Medicaid program that the FQHC undertakes to provide

ATTACHMENT I

CONTRACTOR'S LOCATIONS

CONTRACTOR NAME AND ADDRESS

ATTACHMENT J

CONTRACTOR'S CAPITATION RATES SFY 2022

Please see the attached Rate Books and attachments:
"State Fiscal Year 2022 Risk Adjustment Medicaid Managed Care Program"
Dated December 28, 2021.

ATTACHMENT K

CONTRACTOR'S INSURANCE CERTIFICATES

ATTACHMENT L

RATE-SETTING PROCESS

Please see the attached Rate Books and attachments:
"State Fiscal Year 2022 Risk Adjustment Medicaid Managed Care Program"
Dated December 28, 2021.

ATTACHMENT L
RATE SETTING PROCESS

Please see the attached Rate Books:

State Fiscal Year 2022 Medicaid Plan Capitation Rate Certification: July 1, 2021 through June 30, 2022

Dated December 16, 2021.

ATTACHMENT N

SPECIAL TERMS & CONDITIONS

ATTACHMENT N
SPECIAL TERMS & CONDITIONS

1. Definitions

1. **Actuarial Certification:** Actuarially sound capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

2. **Attribution**: Attribution is the process for defining the population of members for whom an Accountable Entity is held accountable for cost and quality of care.

   For this Contract Period and for any subsequent Contract Period, the Attribution methodology for the Comprehensive Accountable Entity is set forth in the Attribution Guidance included as an attachment to, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners.

3. **Baseline Medical**: Baseline Medical means one hundred percent (100%) of the Baseline Medical Expense for Risk Corridor for each Premium Rating Group as identified in Attachment J including SOBRA payments for maternity-related services, if applicable.

   Per Attachment J, Baseline Medical includes Base Benefit Expense plus Care Transformation Collaborative Expense plus Care Coordination Expense. Baseline Medical does not include Administrative Cost Allowance, Risk Margin, Vaccine Assessment, or Premium Tax. The baseline medical amount is not reduced for the withhold amount.

   For Risk/Gain Share purposes, the MCO-specific Baseline Medical Expenses are adjusted using the risk adjustment results.

   Baseline Medical excludes any payments made to Contractor pursuant to Section 2.15.10 (Incentive Payments) of this contract and Section 2.08.02.04 (STP and the Medicaid Infrastructure Incentive Program) of this contract.

4. **Capitation Rate**: Capitation Rate, as referenced in Attachment J, is the capitation rate payment made by EOHHS to the Contractor for members for each Premium Rating Group. This rate includes the Baseline Medical Expense for Risk Corridor, Administrative Cost Allowance, Risk Margin, Vaccine Assessment, and Premium Tax. The capitation rate is reduced for the Withhold arrangement.

   The MCO-specific capitation rates are adjusted using the risk adjustment results.

5. **Contract Period:** The Contract Period means each 12-month period beginning July 1, and ending June 30, of the next year.

6. **Gain Share:** Gain Share means the terms by which EOHHS and the Contractor share in the gain realized from participating in the program for a Contract Period. This is when Medical Expenses are less than Baseline Medical.

7. **Incentive Payments:** Incentive payments are payments designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. The Contractor's receipt of incentive payments is based solely on satisfactory performance and is not conditional on the Contractor's compliance with an Inter-governmental agreement.

8. **Medical Expenses**: Medical Expenses means those benefits and services that the Contractor is obligated to provide and pay for pursuant to Attachments A, O, and P during the Contract Period. Services that are not contractual requirements are not to be included in Medical Expense.

   Medical Expenses shall be the sum of paid claims, substantiated by encounter data, accrued medical expenses, and allowable general ledger claims adjustments including the following:

   - Expenses paid to an Accountable Entity based on a TCOC Shared Savings Payment arrangement.

   - Payment received from an Accountable Entity based on a TCOC Shared Losses Payment arrangement.

   - Savings from recoveries from other payers including those pursuant to coordination of benefits, third-party liability (TPL) collections, and subrogation.

   - Savings from reinsurance recoveries made to the Contractor.

   - Expenses for reinsurance payments made by the Contractor.

   - Savings from drug rebates received or receivable for drug payments or drug payment adjustments made to the Contractor.

   - Medical claims payments made by the Contractor paid outside of the claims payment system.

   - Interpreter services paid outside of the claims system.

   - Care Coordination include services that can be substantiated through record review. Care Coordination expenses are to be limited to the Care Coordination premium revenue received by the Contractor, defined as the Care Coordination

per member per month amount illustrated in the MCO risk adjustment report, multiplied by the count of capitation payments received by the Contractor.

- Other expenses made for obligated services that can be substantiated through record review.

Medical Expenses shall not include:

- Out-of-plan benefits as detailed in Attachment B.
- Non-covered services as detailed in Attachment C.
- Provider incentive arrangements that were not approved by EOHHS or that exceed EOHHS approved levels.
- Expenditures for the administrative portion of payments made to subcontractors or through intercompany arrangements for administration and/or payment of covered services including, but not limited to, arrangements for Durable Medical Equipment (DME), pharmacy (Rx), and behavioral health (BH).
- Expenditures for administrative expenses made to vendors, subcontractors, or through intercompany arrangements for services such as claims recovery expenses, payment integrity, and claims audit services.
- Payments made pursuant to Section 2.15.10. (Incentive Payments) and Section 2.08.02 (Contracting with EOHHS Certified Accountable Entities, inclusive of Sections 2.08.02.01 through 2.08.02.07) of this contract.

9. **Premium Rating Group**: Those groups, as defined in Attachment J, for which the EOHHS issues a capitation payment to the Contractor on a PMPM basis or a per delivery basis for SOBRA payments.

10. **Quarter:** Quarter means a calendar quarter (e.g., January 1 through March 31, April 1, through June 30, July 1 through September 30, and October 1 through December 31).

11. **Risk Corridor:** Risk Corridor is determined by the difference between the Contractor's Baseline Medical and Medical Expenses. The Risk Corridor is used to determine the extent of the Gain Share or Risk Share between EOHHS and the Contractor.

12. **Risk Share:** Risk Share means the terms by which EOHHS and the Contractor share in the loss realized from participating in the program for the duration of a Contract Period. This is when Medical Expenses are greater than Baseline Medical.

13. **Reinsurance:** The Contractor will reinsure Medical Expenses for its members. Such costs will be a component of Medical Expense that will be reduced by any claim payment recoveries received from the reinsurer.

14. **Total Cost Of Care Shared Savings Payment**: A Total Cost Of Care (TCOC) Shared Savings Payment is made by the Contractor to an Accountable Entity when the Accountable Entity's actual TCOC is lower than their TCOC benchmark after the quality adjustment.

    For example, in a 50%/50% shared savings arrangement, if the targeted TCOC is $100 and the actual AE's TCOC expenses are $90, there is a shared savings of $10, after the quality adjustment. At the end of the contract period, the $5 shared savings is paid to the AE by the Contractor. this payment increases the Contractor's Medical Expenses by $5, and the Contractor retains $5 of the shared savings dollars.

    TCOC methodology is reviewed and approved by EOHHS and must be compliant with both 42 CFR §438.61 and the requirements articulated in the Special Terms and Conditions of the RI Medicaid 1115 waiver, specifically the *Rhode Island Medicaid Accountable Entity Program Attachment l1: Accountable Entity Total Cost of Care Requirements.2*

15. **Total Cost of Care Shared Risk Payment**: A Total Cost of Care (TCOC) Share Losses Payment is made by an Accountable Entity to the Contractor when the Accountable Entity's actual TCOC is higher than their TCOC benchmark.

    For example, in a 50%/50% shared risk arrangement, if the targeted TCOC is $100 and the actual TCOC is $110, there is a shared risk of $10, after the quality adjustment. At the end of the contract period, the $5 shared risk is recouped from the AE by the Contractor. This recoupment decreases the Contactor's Medical Expenses by $5, and the Contractor retains $5 of the shared risk dollars.

16. **Withhold Arrangement:** A Withhold Arrangement is when the State may institute financial rewards for the Contractor for meeting performance targets, specified in the contract, that are designed to drive managed care plan performance in ways distinct from the general operational requirements under the contract.

17. **Withhold Arrangement between the Contractor and an AE in a Shared Risk Arrangement:** In the event of a shared risk arrangement with an AE, or any other entity in a shared risk arrangement, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this, upon entering into such agreement, the Contractor will set forth a clear arrangement (e.g., a withhold or escrowed funds) to ensure that funds are available for financial settlement if Medical Expenses exceed the Total Cost of Care for the performance period.

2. Risk Share/Gain Share Arrangement

---

142 CFR §438.6: *Special contract provisions related to payment*, https://www.ecfr.gov/cgi-bin/text-idx?sid=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

2http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/AE%20PY2%20Documents/Attachment%20L%201%20(TCOC%20Requirements)_PY%202%20FINAL.pdf

The Risk Corridor for a Contract Period is based on the cumulative Baseline Medical and Medical Expense for each product line (e.g. Rhody Health Partners). The Risk Corridor is determined by calculating cumulative Baseline Medical minus cumulative Medical Expenses.

For Risk/Gain Share purposes, the MCO-specific Baseline Medical Expenses are adjusted using the risk adjustment results.

If actual cumulative Medical Expenses are greater than Baseline Medical, Risk Share provisions as shown below apply.

Risk Share

1. If the actual cumulative Medical Expenses are between one hundred percent (100%) of the Baseline and one hundred and three percent (103%) of the Baseline, the Contractor will bear one hundred (100%) of those expenses.

2. If the actual cumulative Medical Expenses are between one hundred and three percent (103%) of the Baseline and one hundred five percent (105%) of the Baseline, the Contractor will bear forty percent (40%) of that expense and EOHHS will bear sixty percent (60%) of that expense.

3. If the actual cumulative Medical Expenses are greater than one hundred five percent (105%) of the Baseline, the Contractor will bear ten percent (10%) of that expense and EOHHS will bear ninety percent (90%) of that expense.

If actual cumulative Medical Expenses are less than Baseline Medical, then Gain Share provisions apply.

Gain Share

1. If the actual cumulative Medical Expenses are between ninety- seven percent (97%) of the Baseline and one hundred percent (100%) of the Baseline, the Contractor will retain one hundred percent (100%) of those gains.

2. If the actual cumulative Medical Expenses are between ninety-seven percent (97%) of the Baseline and ninety-five percent (95%) of the Baseline, the Contractor will retain forty percent (40%) of those gains and EOHHS' share will be sixty percent (60%).

3. If the actual cumulative Medical Expenses are less than ninety-five percent (95%) of the Baseline, the Contractor will retain ten percent (10%) of those gains and EOHHS' share will be ninety percent (90%).

The Risk and Gain Share arrangements are summarized in **Table 1** below.

Table 1. Risk and Gain Share Arrangement

Risk Sharing Provisions	**Plan Share of Risk**	**EOHHS Share of Risk**
For Medical Expenses between 100% and 103% of Baseline	100%	0%
For Medical Expenses between 103% and 105% of Baseline	40%	60%
For Medical Expenses greater than 105% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gains**	**EOHHS Share of Gains**
For Medical Expenses between 97% and 100% of Baseline	100%	0%
For Medical Expenses between 97% and 95% of Baseline	40%	60%
For Medical Expenses less than 95% of Baseline	10%	90%

All Contractor's contracts for Medicaid enrollees that include medical claims services, including Accountable Entity arrangements, must be available for review by EOHHS or its agents. If these contracts are not made available, they will be excluded from Risk-Share/Gain-Share arrangement and from the Accountable Entity arrangements.

To further ensure the integrity of the Contractor's controls and financial reporting, EOHHS requires that their external auditors, in their Annual Report of Independent Auditors or, in a separate letter to Management and EOHHS, specifically address their review and testing of the Contractor's Risk Share/Gain Share financial statements including the related Contractor's Receivable and/or Payable to/from EOHHS as of December 31 of each year.

Also, the Contractor's Independent Auditors are required to review and test the annual final Accountable Entities (AE) Total Cost of Care (TCOC) performance statements and the related shared-savings or shared-risk to/from the AEs and report their findings in the same manner as described above for the Contractor's Risk Share/Gain Share financial statements.

Also, per 42 CFR 438.604, the Contractor shall attest that their reports have been reviewed for completeness, accuracy, and that the submission, to the best of the Contractor's knowledge, represents reporting requirements set forth by EOHHS in its contract with the Contractor.

In addition, per 42 CFR 438.606, Contractor shall certify data from one of the following individuals:

- Chief Executive Officer,
- Chief Financial Officer,
- An individual with delegated authority who reports directly to the Contractor's CEO or CFO and who is authorized to sign on their behalf.

EOHHS, and/or its designee, will conduct, at the Contractor's location, an audit of the Contractor's revenues and expenses as detailed in the Contractor's Risk Share/Gain Share reports, Accountable Entities' and TCOC financial statements, and any other financial submissions provided by the Contractor to ensure that the financial information provided is accurate and compliant, as defined in the MCO's Contracts with EOHHS and this Attachment N. The specific revenue and expense areas to be audited are to be determined by EOHHS, and/or its designee. The audit of these reports will occur no less than once every three (3) years, with reasonable notice to the Contractor.

3. Monthly Risk Share/Gain Share Reporting

The cumulative Risk Share/Gain Share Report for the Contract Period will be submitted each month on a form set forth by EOHHS, including the Attestation as to the accuracy and completeness of the reports. A separate Risk Share/Gain Share report will be completed by the Contractor for each premium rating group covered by the Contractor. EOHHS will review the Risk Share/Gain Share Report submissions on a routine basis, and the parties will mutually seek to resolve any questions concerning the dollar amounts on the risk/gain-share reports.

If, six (6) months after the start of a Contract Period, the Contractor's Risk Share/Gain Share Report indicates that Medical Expenses and Baseline Medical vary by (30%) or more, EOHHS may make partial settlement payments or recoupments on an interim basis prior to the end of the Contract Period and/or the final settlement period. Related Risk Share payments will be based on cash expenditures as shown in the Risk Share/Gain Share Report. Related Gain Share recoupments will be based on Risk Share/Gain Share reports that are inclusive of IBNR. If this situation occurs, EOHHS will provide the Contractor with notice of the payment or recoupment dollar amount at least forty-five (45) calendar days in advance of the actual date of the payment or recoupment.

4. Risk Share/Gain Share Reconciliation and Payment/Recoupment

At the end of the contract year, the Contractor will submit to EOHHS their preliminary Risk Share/Gain Share reports. Within 60 days of receipt of these reports, EOHHS will either pay or recoup 80% of the outstanding balance indicated on the Contractors' year-end Risk Share/Gain Share reports.

Within 60 days after the 12-month claims runout period for the contract year, the Contractor will submit their final Risk Share/Gain Share reports to EOHHS. Within 60 days of receipt of these reports, EOHHS will either pay or recoup 80% of the outstanding balance indicated on the Contractors' final Risk Share/Gain Share reports.

Final settlement of the Contactors' Risk Share/Gain Share reports is based on EOHHS' reconciliation of the Premium Rating Group's Membership, Baseline Medical, Medical Expenses, and general ledger adjustments provided by the Contractor. EOHHS will make every effort to complete its reconciliation for settlement within 90 days of receipt of the final Risk Share/Gain Share reports

If, however, EOHHS requests the Contractor to assist in the Risk Share/Gain Share report reconciliation of the Contractor's reports, Contractor agrees to submit the reconciliation to EOHHS within fifteen (15) business days after the request from EOHHS. In the event the Contractor's response takes longer to be submitted, EOHHS may, at its discretion, move forward to final settlement of the Contractor's Risk Share/Gain Share reports without regard to any additional data that the Contractor may provide.

The final Risk Share/Gain Share Report will include no allowance for incurred but not reported (IBNR) claims. For each Contract Period, risk/gain sharing will be based only on claims paid for covered services for eligible and enrolled members during the applicable Contract Period. To assure fairness in resolving outstanding claims, EOHHS will allow inclusion of claims for services provided to eligible and enrolled members for a period not to exceed three hundred sixty-five (365) days from the date of a Covered Service.

ADDITIONAL SPECIAL TERMS AND CONDITONS

5. MLR Reporting

Contractor is required to submit a consolidated MLR report using the *Medicaid Managed Care Program: Medical Loss Ratio Calculation* workbook and template provided by EOHHS for their Medicaid population for each MLR reporting year, specifically as defined in 42 CFR 438.8(e), 42 CFR 438.8(f), 42 CFR 438.8(h) and 42 CFR 438.8(i). Contractor shall comply with the general directives as outlined in the remainder of 42 CFR 438.8 and any EOHHS directives required to satisfy the MLR requirements outlined in 42 CFR 438.74. Reports containing the enumerated list of items shall be submitted by the earlier of the EOHHS stated deadline or within twelve (12) months of the end of the year. Contractors should use the reporting tool provided by EOHHS to report the MLR reporting requirements for each state fiscal year.

The Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting, in accordance with 42 CFR 438.8(k)(3).

6. SOBRA Reporting

SOBRA related expenses are to be reported using the following CPT codes (treatment) and ICD-10 codes (diagnosis):

Note: The following is a revised definition as of April '08 (Excludes V25 as criteria)."

	MC SOBRA-Related Maternity Criteria	
59400 ≤ CPTx ≤ 59430 59500 ≤ CPTx ≤ 59530 59600≤ CPTx ≤ 59630	**Any Procedure Code**	**On or After 10/1/2015**
640xx ≤ Dx1 ≤ 679.99 V22xx ≤ Dx1≤ V23.99 V26xx ≤ Dx1 ≤ V27.99	**Primary Diagnosis**	>="o00" And <="o9a99" >="z34" And <="z3499" >="z31" And <="v3799"
V24xx ≤ Dxx ≤ V24.99	**Any Diagnosis**	>="z39" And <="z3999"

7. Payments to Certified Patient Centered Medical Homes

For all enrolled adult members whose medical home is a participating practice in the Rhode Island Care Transformation Collaborative (CTC), the Contractor shall pay the negotiated per member per month rate, quality incentive payments, and administrative component, as outlined in: **ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2022.**

For all enrolled pediatric members whose medical home is (a) certified as a Patient Centered Medical Home, (b) a participating practice in the CTC or PCMH-Kids program, or (c) a graduate of the PCMH-Kids program, the Contractor shall pay the negotiated per member per month rate, quality incentive payments, and administrative component, as outlined in:
ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2022.

For practices that have graduated from PCMH-Kids and maintain OHIC PCMH recognition, the Contractor shall at a minimum adopt the following key components in alignment with those detailed in the CTC Pediatric Common Contract: care management payment, reports, performance incentive, and provider responsibilities. Rates for care management and quality incentive payments shall be made in accordance with:
ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2022.

8. State's Right to Open Up Participation

The State reserves the right, after contract award, to open-up participation, without competition, to other health plans, including ones meeting the definition of a Medicaid managed care organization under Section 4701 of the Balanced Budget Act of 1997.

9. Stop-Loss Claiming

10. Incentive Payments Regulations

If the Contractor is eligible for incentive payments, and in accordance with 42 CFR 438.6(b)(2), payments under incentive arrangements may not exceed 105 percent of the approved capitation rate since such total payments will not be actuarially sound. Additionally, per 42 CFR 438.6(b)(2)(i), the incentive arrangement must be for a fixed period and performance and is measured during the rating period under the contract in which the arrangement is applied. Also, 42 CFR 438.6(b)(2)(iv) states that participation is not conditional on entering into or complying with an inter-governmental transfer agreement. Please refer to the state's Quality Plan for further information.

ATTACHMENT O

MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY SERVICES FOR CHILDREN

ATTACHMENT O:
MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY SERVICES FOR CHILDREN----

---

The Contractor requirements for mental health and substance use services as set forth in Sections 2.06, 2.08, and 2.09 and ATTACHMENT A is described below.

MENTAL HEALTH PARITY

The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by the Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits.

In addition, the contractor agrees that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than the plan's non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

MENTAL HEALTH AND SUBSTANCE USE SERVICES

The Contractor commits to providing children a full continuum of mental health and substance use services. The Contractor's services will address all levels of need. These include but are not limited to:

ACUTE SERVICES:

Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Emergency Service Intervention:** 24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an

imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment.

- The discharge plan will be shared with the member's pediatrician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.

- The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

1. Alcohol Related Disorders
2. Anxiety Disorders
3. Mood Disorders

2. **Observation/Crisis Stabilization/Holding Bed:** A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

3. **Inpatient Acute Hospitalization:** Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

4. **Acute Residential Treatment:** A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

INTERMEDIATE SERVICES:

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Partial Hospitalization (PHP):** A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

   A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For children and adolescents, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the child's symptoms improve and a transition plan effectively transitions the child back to family, community and school setting. The PHP consults and coordinates the member's care with the child's parent/guardian, other treating providers and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's

clinical needs. It is recommended that this is provided at least twenty (20) hours per week for BH and/or SUD

- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
- The Contractor will be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

2. **Day/Evening Treatment:** A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Children and adolescents who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

3. **Intensive Outpatient Treatment (IOP):** A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.

4. **Enhanced Outpatient Services (EOS):** Home/community based clinical services provided by a team of specialized licensed therapists and case managers. (Some examples of EOS clinical specialists include providers with expertise in the treatment of Developmental Disabilities, Sexual Abuse, and Post Traumatic Stress Disorder). The goal of EOS is to offer an effective and clinically supported transition of care from an inpatient or residential setting or to avoid an inpatient or residential admission for high-risk members.

Providers offer prompt access to this service and are able to provide varying levels of service intensity (multiple times per day and tapering to multiple times per week) to meet the unique needs of children and their families. This service may be used to assist a child transitioning from an inpatient stay or to prevent an admission.

Minimum program requirements include:

- Home/community based clinical services provided to meet the member's clinical needs. It is recommended that services are provided for up to 5 days per weeks.
- Services are provided to the member based on the member's need. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

OUTPATIENT SERVICES:

1. **Traditional outpatient services, including:**

- Diagnostic evaluation
- Developmental evaluations
- Psychological testing
- Individual therapy
- Family therapy
- Group therapy
- Medication management

2. **Home and Community Based Services for Individuals under Age 21 Years of Age** (as described below):

1. Background and Overview

Home Based Treatment Services (HBTS), Personal Assistance Services & Supports (PASS), Respite, Evidence Based Practices (EBP) and Adolescent Residential Substance Use Treatment are designed for children with complex health needs. These services intended for children with complex health needs have historically been accessible outside of the MCO's scope of benefits through Medicaid Fee- For- Services (FFS). EOHHS intends to integrate all home and community-based services for children and adolescents in an effort to meet Rhode Island's goals of the Triple Aim and to provide continuity and appropriate service delivery to children and their families. It is intended that the Contractor will further expand the service array available for children enrolled in the Contractor's Health Plan and fully manage the health care of the whole child within the context

of their families. The Contractor must provide these services to any Medicaid member under age 21, per Federal EPSDT regulation. Services are not specific to any particular product line or population but are intended to meet the needs of children with serious or chronic health needs to attain their fullest potential and to remain as independent as possible within their communities. The Contractor will assess members for medical necessity criteria, based on the guidelines outlined below.

2. Goals

Specialized programs for children with complex health needs should be provided in a holistic, person and family centered way. Services should be provided to improve member outcomes by integrating social, behavioral health, and physical health needs. For some, selective services will be provided over extended periods of time, to assist with chronic condition management and prevent acute inpatient admissions and transitions to higher costs settings. The overarching goals of these services follow the Triple Aim approach:

Improve Care and Access	• Improve overall health and quality of life of children and families • Improve family ability to manage symptoms/behaviors in the home • Improve ability for children to thrive in their communities
Reduce Cost	• Decrease utilization of the ER • Decrease utilization of higher costs settings such as hospitals or residential placements • Encourage alternative payment methodologies for these services
Improve Quality	• Promote evidence-based practices • Encourage provider incentives to improve quality of care

3. Program Description by Service

A. Home Based Treatment Services (HBTS):

HBTS is an intensive home or community-based service for children and adolescents who have chronic, moderate, or severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning is significantly compromised. HBTS is a phased system approach that includes in person, high frequency, specialized treatment (including Applied Behavioral Analysis discrete trial interventions) and supervision of direct care staff. HBTS is administered routinely with the child/adolescent and parents/guardians engaged in treatment. Children may require up to 20 hours per week, or

more as clinically indicated. Key goals of this treatment are person/family centered and could include: a) Increased ability of caregiver to meet the needs of their child/adolescent; b) increased language and communication skills; c) improved attention to tasks; d) enhanced imitation; e) generalized social behaviors; f) developing skills for independence; g) decreased aggression and other maladaptive behaviors; and h) improved learning and problem-solving skills. The Contractor is responsible for contracting with providers to provide the level of service indicated in this section and ensure timely and needed access to these services per EOHHS Practice Standards.

Core Components:

HBTS is composed of various service components, including:

Assessment and Treatment Planning

1. Assessment of the functional needs of the child and family, utilization of all referral and collateral information (i.e., IEP, IFSP, contact with providers/teachers, review relevant medical or behavioral health evaluations/records), and maintaining ongoing parent/caregiver/guardian communication.
2. Identification and prioritization of treatment goals and objectives that are written to be clear to families, specific and measurable. Interventions will be clearly defined, and research based. The level of parent participation will be clear and consistent. Parents/Caregivers/Guardians must sign all proposed Treatment Plans.

   i. HBTS Treatment Consultation Services

   Treatment Consultation is intended to bring specific expertise and direction to the treatment team (i.e., Clinical Supervisor and home-based worker). It can be offered on a broad basis or by using Specialty Consultations from licensed Occupational Therapists (OT), Physical Therapists (PT), Psychologist, or Speech and Language Pathologists (SLP). HBTS Treatment Consultation is available before direct services begin (i.e., Pre-Treatment), during a course of HBTS care (Treatment Consultation and Specialty Consultation), and at the conclusion of HBTS (Post-Treatment).

   ii. Treatment Coordination

   Treatment Coordination represents activities by a team member on behalf of a specific child receiving HBTS services to ensure coordination and collaboration with parents, providers, the medical home, and other agencies (e.g., school, Early Intervention, DCYF or FCCP) including the referral source. Collaboration and communication is ongoing throughout a child's course of HBTS.

   iii. HBTS Direct Services

   HBTS consists of Specialized Treatment and Treatment Support. These services can only be provided to a child by a home-based worker in accordance with an

approved Treatment Plan, and under the supervision of a licensed healthcare professional.

iv. HBTS Specialized Treatment

Specialized Treatment is intensive evidence-based intervention that may take place in the child's home, center, and/or community setting, and requires the participation of parents/guardians. For some children/adolescents, HBTS Specialized Treatment may be ABA discrete trial interventions through approved ABA provider-agencies.

HBTS Specialized Treatment is provided on a continuous basis for an approved number of hours per week. The focus of treatment can include: increasing language and communication skills, improving attention to tasks, enhancing imitation, generalizing social behaviors, developing independence skills, decreasing aggression or other maladaptive behaviors, and improving learning and problem-solving skills (e.g., organization, conflict resolution, and relaxation training). It addresses the development of behavior, communication, social, and functional - adaptive skills, and may reinforce skills included in a child's Individual Educational Plan (IEP) or Individualized Service Plan (IFSP). Goals and objectives are defined, written, and tied to specific methods of intervention and measurement of progress. HBTS is not intended to replace or substitute for educational services.

v. HBTS Treatment Support

For some children and adolescents with moderate to severe functional impairments, the frequency and intensity of Specialized Treatment may become too taxing and result in limited benefits such that Treatment Support is indicated. Treatment Support does not represent a minimization of therapeutic effort and is not equivalent to Respite care. Treatment Support uses a portion of HBTS hours for the purposes of providing structure, guidance, supervision, and redirection for the child.

The inclusion of Treatment Support is intended to facilitate a child's ability to remain at home, maintain activities of daily living, participate in the community, and transition into young adulthood. It encourages and promotes the practice of daily living skills by providing structure, supervision, guidance, and redirection while engaging in cognitive, physical, and social activities that would be typical for a child his/her age. The rationale for using Treatment Support must be clearly articulated and linked to one or more of the following domains:

1. The child's ability to acquire and use information.
2. The child's ability to attend and complete tasks.
3. The child's ability to interact and relate with others.
4. The child's ability to care for him or herself.
5. The child's ability to maintain health and physical well-being, which includes participation in community activities.

vi. Applied Behavior Analysis (ABA) Services

ABA discrete trial interventions are highly specialized and a distinct form of basic behavior therapy principles. It is intended that all children and adolescents be considered eligible for ABA services if it is clinically appropriate. It can be overseen by a Board-Certified Behavior Analyst (BCBA) or a licensed trained professional (e.g., Psychologist). The use of ABA discrete trial intervention can require additional hours of material preparation, planning, directing and supervising of direct service staff. This may include more hours for Clinical Supervision and Lead Therapy. These additional supports can only be provided for ABA recognized providers.

vii. Lead Therapy (for ABA only)

Lead therapy is regarded as an administrative support for ABA services. It provides for the development and updating of instructional materials, providing support to families in applying instructional strategies, and gathering and managing treatment data.

viii. Child Specific Orientation for Newly Assigned Home-Based Worker

Child specific orientation provides the newly assigned home-based worker with detailed information about a child's condition, treatment goals and objectives, methods of intervention, and other related aspects of care such as observing the child and/or other staff working with the child and family. It is provided by the Treatment Consultant or Clinical Supervisor and with an experienced home-based worker, when applicable, to prepare new staff to work with a child and family already receiving care.

ix. Clinical Supervision of Specialized Treatment and Treatment Support Workers

The Clinical Supervisor is responsible for the duties and actions of direct service staff. Clinical Supervision serves to ensure effective development, implementation, modification, and oversight of the Treatment Plan. It is the responsibility of the provider-agency to maintain clinical supervision throughout a period of treatment authorization. Additionally, the Clinical Supervisor must educate the home-based staff on issues of domestic violence, substance use and risk to child welfare, harassment of home-based staff or any other serious circumstances that may compromise or interfere with treatment. Specific functions of clinical supervision include:

- Observe worker in the home with the child implementing the Treatment Plan on a monthly basis
- Model techniques for staff and/or work with the child
- Instruct workers on proper implementation of treatment interventions
- Analyze treatment data and assess efficacy of treatment
- Address clinical issues and challenging behaviors including a functional

behavioral analysis for providing direction to the home-based worker

- Assist in development/revisions of the Treatment Plan and writing of goals and objectives
- Communication and collaboration with others (e.g., school personnel, OT, PT, SLP consultants) regarding treatment
- Attend IEP or IFSP meetings, when indicated, in order to maintain or modify Treatment Plan
- In person consultation to home-based worker and family
- Provide group supervision when there are two or more home-based workers treating a child. Group supervision is necessary to maintain optimal communication and ensure consistent implementation of treatment

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

x. Treatment Intensity and Therapeutic Approach

Treatment intensity refers to the number of direct service hours in an approved Treatment Plan. Upon referral, the provider-agency will assess the child and family's current treatment needs and determine the treatment intensity required. Treatment is to be individualized based upon the clinical needs being addressed and done in collaboration with the child's family and all relevant parties involved in developing a plan of care for the child and family.

Treatment intensity must take into account the following factors:

a. The child's age.
b. The child and family's ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress.
c. Type, nature, and course of presenting condition and diagnosis.
d. Severity of presenting behaviors.
e. Other treatment or educational services being received.
f. Impact on family functioning.
g. Presence of co-existing conditions.
h. Presence of biological or neurological abnormalities.
i. Current functional capacities of the child.
j. Family factors (e.g., parenting skills, living environment, and psycho-social problems).
k. Interaction with other agencies or providers.

xi. Staffing

HBTS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANS screening, including the following:

1. Home-Based Specialized Treatment Worker:

a. At least 19 years of age
b. High school diploma/equivalent and two years' experience or currently enrolled in not less than 6 semester hours of relevant undergraduate coursework at accredited college or university

2. Home-Based Treatment Support Worker:
   a. At least 19 years of age
   b. High school diploma/equivalent and one-year experience or Associate's degree in human service field.
3. Clinical Supervisor:
   a. Rhode Island licensed Health Care Provider with established competency working with children with special health care needs. Master's or Doctoral degree.
4. Treatment Consultant:
   a. Rhode Island licensed Health Care Provider in one of the following categories: BCBA, licensed independent clinical social worker, licensed clinical social worker, marriage and family therapist, mental health counselor, psychologist, physical therapist, Occupational Therapist, or Speech and Language Pathologist
5. Treatment Coordinator:
   a. Bachelor's degree at minimum
6. Lead Therapist: (for ABA)
   a. At least 19 years of age
   b. High school diploma/equivalent and two years' experience or an Associate degree in human service field.

   At a minimum, the Contractor is responsible for ensuring that adequate provider access is available for all levels of staffing listed above.

xii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of HBTS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to HBTS at intervals defined by EOHHS. Within six months of the executed contract,

the State and the Contractor will collaboratively identify reportable quality outcome metrics.

xv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Access Point RI (HBTS and ABA Program)
Bradley Hospital (ABA Program)
CBS Therapy (ABA Program)
Family Behavior Solutions, Inc. (ABA Program)
Frank Olean Center (HBTS)
Groden Center (HBTS and ABA Program)
J. Arthur Trudeau (HBTS and ABA Program)
Looking Upwards, Inc. (HBTS)
Momentum, Inc. (ABA Program)
Northeast Behavioral Associates (HBTS and ABA Program)
Ocean State Behavioral (HBTS)
Ocean State Community Resources, Inc. (HBTS)
Perspectives Youth and Family Services (HBTS and ABA Program)
proAbility (HBTS)
Seven Hills (HBTS and ABA Program)
TIDES (HBTS)
United Cerebral Palsy of RI (HBTS)

The Contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

B. Evidence Based Practices (EBP):

EBP are Home and Community Based Treatment modalities that include an array of services to meet the continuum of care a child, adolescent, and family needs.

Core Components:

At a minimum, the Contractor is responsible for ensuring that evidenced based practices, such as the services identified above are available to its members and are part of the continuum of care offered by the Contractor.

i. Staffing

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing needed for the specific EBP.

ii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and FFS, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to the EBP at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

v. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service.

C. Adolescent Residential Substance Use Treatment:

Core Components:
Individualized treatment is determined through comprehensive assessment using ASAM criteria and clinical collaboration. Treatment is strength-based, solution focused utilizing Motivational Interviewing, Cognitive-Behavioral Therapy and evidence-based modalities including Dialectical Behavior Therapy and Aggression Replacement Therapy. Programming combines recreation, life skills curriculums and opportunities for 12-step recovery work with the individual, group and family work each client receives. Treatment is specific to maintaining abstinence and relapse prevention while promoting effective functioning in society with medication prescribing and monitoring where indicated. Referrals are received via hospitals, physicians, call centers, treatment programs, RI Family and Drug Courts, Probation and Parole, DCYF and local school systems.

i. Staffing

Clinical Director, Program Director, counselors/clinicians, education coordinator, recreation coordinator and residential support staff.

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

ii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to adolescent substance use residential programming at intervals defined by EOHHS. The Contractor is responsible for identifying reportable quality outcome metrics.

iv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Caritas ARTS Program.

The Contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

D. Personal Assistance Services & Supports (PASS):

PASS is a comprehensive integrated program that includes intermittent, limited, or extensive one-to-one personal assistance services needed to support, improve or maintain functioning in age-appropriate natural settings. These specialized consumer-directed services are available to children who have been diagnosed with certain physical, developmental, behavioral or emotional conditions living at home. PASS Services are designed to assist children and youth with attaining goals and identifying objectives within three areas: activities of daily living, making self-preserving decisions, and participating in social roles and social settings. The goals of the services provided are to support the family in helping the child participate as fully and independently as possible in natural community settings and to reach his or her full potential.

This is achieved through maximizing control and choice over specifics of service delivery and the child's family assumes the lead role in directing support services for their child.

Core Components:
PASS is composed of various service components, including:

i. Assessment and Service Planning

PASS Agency coordinator works with the family to assure families have the requisite information and/or tools to participate in a consumer-directed approach and to manage the services. The PASS Agency coordinator assesses the family's ability to effectively participate in the delivery of PASS services throughout an authorized period of care. The Service Plan begins with an assessment of the needs and activities of the child and family based upon their daily routines. From the assessment, flows the identification of goals and objectives with details of Service Plan Implementation and monitoring. Service Plans constitute a written agreement for all involved parties and identify roles and responsibilities of each party (i.e., PASS families, direct service worker(s) and PASS Agency). All goals and objectives in the Service Plan and in the scope of the Direct Service Worker activities must be focused in at least one of the three PASS domains: activities of daily living, making self-preserving decisions, and participating in social roles and social settings.

ii. Direct Services

Direct Services are one-to-one personal assistance services provided by a Direct Service Worker under the direction of the parent/caregiver/guardian in accordance with an individualized approved Service Plan. Under Direct Services, designated family supervisor(s) will direct the scope, content and schedule of worker activities and evaluate their performance.

iii. Service Plan Implementation

PASS Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

iv. Clinical Consultation

Provides family, Direct Service Workers, and the child with clinical guidance through reviews of goals and objectives, observations of a child's progress, providing recommendations for effective strategies and approaches and for methods for monitoring and tracking progress.

v. Treatment Intensity

Treatment intensity refers to the number of direct service hours in an approved Service Plan. It is the PASS Agency's responsibility to determine the level of treatment intensity necessary to promote the achievement of treatment objectives. Treatment intensity is based on the individual needs of a child. Collaboration with the child's family and all relevant parties involved in developing an individualized plan of care for the child is required and will be maintained throughout a period of treatment (e.g., HBTS, behavioral health, physician, school personnel, or other agencies). Arriving at a level of treatment intensity must take into account the following factors:

1. The child's age.
2. Ability to engage in sustained treatment (e.g., span of attention, stamina,

developmental level, etc.) and expectations for progress.
3. Type, nature, and course of presenting condition and diagnosis.
4. Severity of presenting behaviors.
5. Other treatment or educational services being received.
6. Impact on family functioning.
7. Presence of co-existing conditions.
8. Presence of biological or neurological abnormalities.
9. Current functional capacities of the child.
10. Family factors (e.g., parenting skills, living environment, and psycho-social problems).
11. Interaction with other agencies or providers.

At a minimum, the Contractor is responsible for ensuring that all above services are available to its members and are part of the continuum of care offered by the Contractor.

vi. Staffing

PASS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANTS screening, including the following:

1. Direct Service Worker
   a. At least 18 years of age
   b. High school diploma/equivalent
   c. No financial responsibility for child and does not live in household
   d. Demonstrated ability to carry out specific tasks outlined in service plan

2. PASS Agency Coordinator
   a. Bachelor's Degree in human services or related field
   b. One-year minimum experience
   c. Demonstrated competency working with families of children with special health care needs

3. Clinical Consultant: Rhode Island licensed Health Care Provider with minimum two (2) years' experience working with children with special health care needs
   a. Licensed independent clinical social worker
   b. Licensed clinical social worker
   c. Board Certified Behavior Analyst
   d. Registered nurse with Master's Degree
   e. Psychologist
   f. Physical therapist, occupational therapist, or speech and language pathologist
   g. Mental health counselor
   h. Marriage and family therapist

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

vii. Level of Care Criteria

After the PASS transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between the Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of PASS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

ix. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to PASS at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

x. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Access Point RI
Frank Olean Center
Groden Center
J. Arthur Trudeau Memorial Center
Looking Upwards, Inc.
Momentum, Inc.
Northeast Behavioral Associates
Ocean State Behavioral
Ocean State Community Resources, Inc.
Perspectives Youth and Family Services
proAbility
Seven Hills
United Cerebral Palsy of RI

The Contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider.

E. Respite:

Respite services are family directed caregiving supports available for families of children (birth-21) that meet an institutional level of care criteria. Families who are eligible receive an annual allotment of at least 100 hours of respite services. Additional hours may be utilized to prevent the

need for more intensive services and supports. Respite agencies manage, hire, and provide payment to respite workers. Respite workers are chosen by the family and the hours may be utilized as determined by the family. The Contractor must offer the family at least 100 hours of respite services, per year.

Core Components:
Respite is composed of two service components, including:

i. Assessment of Safety/Service Plan

Respite agency conducts a brief assessment of child's preferred and allowable activities, methods for communicating, health and safety issues for development of a service and safety plan.

ii. Respite Service

Respite Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

iii. Staffing

Respite is provided by the following staff persons, including:

iv. Respite Program Coordinator

Minimum Associates Degree and one-year experience working with families of children with special health care needs or at least three years' experience working with families of children with special health care needs.

v. Respite Worker

At least 18 years of age with no financial responsibility for child and does not live in household. At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

vi. Level of Care Criteria

After the Respite transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. This criterion must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

vii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to Respite at interval defined by EOHHS. Within six months of the executed contract, the State and the Contractor will collaboratively identify reportable quality outcome metrics.

ix. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

The Autism Project
Access Point RI
The Groden Center
J. Arthur Trudeau Memorial Center
Northeast Behavioral Associates
Ocean State Behavioral
Ocean State Community Resources, Inc.
Seven Hills Rhode Island

The Contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider.

4. EOHHS Certification Standards

EOHHS has designed certification standard for its Medicaid FFS providers. The Contractor will use these certification standards as a guideline in designing the Contractors' programs. To assure comparability, the Contractors programs will not deviate substantially from the EOHHS Certification standards. All of the Contractors program standards and guidelines must be provided to EOHHS for review and approval.

5. Services with Existing Referral Lists

There is an existing referral list for HBTS (including ABA services). The Contractor will continually evaluate all individuals on the referral list and provide them with suitable services which address their unique clinical needs. The Contractor will be responsible for reporting to EOHHS monthly until such time that no members remain on the referral list.

6. Reductions in Savings:

EOHHS has assumed savings for children's behavioral health programs in the current rates and contracts. Saving estimates have been reduced to ensure timely access to services and increase provider participation. The Contractor will insure appropriate reimbursement adjustments to children's Home-Based Therapeutic Services (HBTS) and Applied Behavior Analysis (ABA providers. It is the expectation that the Contractor provides services to all children currently on the waitlist as described in the section above.

ATTACHMENT P

BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

ATTACHMENT P
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

The following provides a description of the Integrated Health Home Program (IHH) and the Assertive Community Treatment Programs (ACT). These services are specific to individuals with serious mental illness. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS, BHDDH, and the Contractor will work together to transition these services from Fee-for-Service into managed care. EOHHS recognizes as this transition occurs, the program and service features may change. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

Adults with serious mental illness require specialized programs that deliver recovery-oriented care, addressing all clinical needs both behavioral and medical. These specialized programs are responsible for ensuring integration of care which includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports. The performance of these programs will be measured, and the goal is improved access to high quality community-based services and decreased costs.

The specialized programs will be for adults with a range of serious mental health illness identified based on diagnostic characteristics. The specialized programs described in this document which will be carried out by the Community Mental Health Organizations (CMHOs) licensed by BHDDH are referred as: Assertive Community Treatment (ACT) and Integrated Health Homes (IHH). Program monitoring and evaluation by the Contractor is required to ensure validity to the model and the effective implementation of responsibilities and functions by the Managed Care Organizations and the CMHOs. The program will be supported by BHDDH regulations.

It is the State's expectation that for those members who are active with a Health Home, the care manager on site at the Health Home will be the Lead Care Manager for that member. Contractor's care management staff will coordinate between the Health Home and any necessary physical health care a member may need. The Contractor will have a designated Lead Care Coordinator or Care Manager to work directly with the CMHO and OTP Health Homes. The Contractor will employ predictive modeling tools that identify and stratify members at risk. If an at-risk member is identified, they will be referred to a Health Home.

The Contractor will have policies and procedures that document how the Contractor will conduct transitions of care and hospital discharge activities, to ensure all appropriate medical, social, and behavioral health needs are met when a member transitions back to the community.

2. Goals

The specialized programs for adults with serious mental illness will be a holistic, person- centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and

preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	• Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	• Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	• Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Mental Health Parity

The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by the Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits.

In addition, the contractor agrees that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than the plan's non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

Program Description

Target Populations

Eligible participants in ACT or IHH must be eighteen (18) years or older and are actively enrolled in the following Medicaid product lines: RIte Care, Medicaid Expansion, and Rhody Health Partners (RHP).

Participants are initially defined by their diagnostic characteristics, specifically a primary DSM V/ICD-10 mental health diagnosis. To be eligible for ACT and IHH participants must also meet the appropriate level of acuity as defined by the State approved standardized assessment tool Daily Living Activities Functional Assessment (DLA).

- ACT participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- Individuals who do not meet diagnostic criteria but require IHH services due to significant functional impairment as measured by the state approved standardized assessment tool, may be admitted to the program through an appeals process established by the State.

Core CMHO Functions and Responsibilities

The CMHOs will carry out the following functions under both ACT and IHH Programs:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the standardized tool, DLA, to identify participant.
- Based on Assessment score, determine and place individual in appropriate specialized program level of service: IHH or ACT. Individuals that do not meet IHH or ACT will not be assigned to the programs and but remain eligible for services and care management in the community.
- Develop a person-centered, individualized Care Plan
- For all Health Home admissions, discharges and transfers, a State approved enrollment form must be completed and kept in the client's medical record. If a client is already enrolled in a Health Home program it is up to the Provider to coordinate with the client's current Health Home Provider
- Carry out treatment and recovery services with fidelity to the ACT model of care
- Carry out treatment and recovery services in the IHH model of care
- Actively use Current Care for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the Current Care program

- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Collaborate to create new delivery system capacity as needed through on-going evaluation of the needs of the system.
- Work with the Contractor's care management staff to facilitate access to the member's PCP and specialty medical providers.
- Work with the Contractor's utilization review staff to ensure timely access to follow-up care, post inpatient psychiatric hospitalization, including medication reconciliation.
- Submit required the Contractor and EOHHS metric reporting and data exchange
- Coordinate with the Opioid Treatment Provider (OTP) Health Home Program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, IHH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the CMHO's ability to provide the services required for IHH or ACT within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The ACT and IHH specialized programs both use a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. Care is provided with fidelity to the evidence-based practices of ACT and IHH. The model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from mental illness. Active treatment and supports are provided with cultural competence.

Program Definitions

Assertive Community Treatment (ACT) Services provided through RI Integrated Health Homes (IHH) have the responsibility to coordinate and ensure the delivery of person-centered care; provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital

admissions/readmissions and avoidable emergency room visits. Regardless of the level of care, these outcomes are achieved by adopting a whole person approach to the consumer's needs and addressing the consumer's primary medical, specialist and behavioral health care needs; and providing the following comprehensive/timely services:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The ACT team is available to provide services 24 hours per day seven days per week, 365 days per year. An ACT team is best conceptualized as continuous care team that functions as a vehicle to provide an array of clinical services or practical needs a person requires. As the provider of most of the services, the continuous care team assures that the services are integrated and provided in the context of the client's current needs, with all activities directed toward helping the client to live a stable life of quality in the community. A major focus of the team is to help the client to gain the skills and confidence needed to move toward greater degrees of independence.

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

IHH activities are focused in four areas:

1. **Care coordination and health promotion**

   Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, collaborate with primary and specialty care providers as required and provide education about medical medications (e.g., educating through written materials, etc.). The Health

Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. Chronic condition management and population management

The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;
- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team.
- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their psychiatric and medical issues to live in the community. This includes:
    - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).
    - Find housing which is safe, of good quality and an affordable place to live-apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).
    - Provide ongoing assessment, problem solving, side-by-side services, skill training, supervision (e.g. prompts, assignments, monitoring, and encouragement) and environmental adaption to assist support client to maintain housing).

- Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services.

- Develop skills related to reliable transportation (help obtain driver's license, use of mass transit, arrange for cabs.

- Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client 's social and interpersonal activities in community settings) e.g. Plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including side-by-side support and coaching.

- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:

  - Support the client to consistently adhere to their medication regimens (e.g. daily scheduling, delivering and supervision of medication regime, telephone prompting, Motivational interviewing, etc.), especially for clients who are unable to engage due to symptom impairment issues.

  - Accompanying clients to and assisting them at pharmacies to obtain medications.

  - Accompany consumers to medical appointments, facilitating medical follow up.

  - Provide side-by-side support and coaching to help clients socialize (e.g. going with a client to a baseball game, etc.) - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

3. Comprehensive transitional care

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will communicate and ensure collaboration between consumers, professionals across sites of care and the Contractor's care management and utilization review staff potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

a. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

b. Upon hospital discharge (phone calls or home visit):

i. Ensure that reconciliation of pre-and post-hospitalization medication lists is completed.

ii. Assist consumer to identify key questions or concerns.

iii. Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow- up appointments.

iv. Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).

v. The Contractor's care management and utilization review staff will work with the IHH team to review transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to IHH consumers – to clarify all outstanding questions.

c. Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

IHH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized psycho-education about the client's illness and the role of the family and their significant people in the therapeutic process. Also, to assist clients with children regarding service coordination (e.g. services to help client fulfill parenting responsibilities; services to help client restore relationship with children, etc.).

IHH peer support specialists will help IHH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support serves to validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

a. Help clients establish a link to primary health care and health promotion activities.

b. Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.

c. Assist clients in making behavioral changes leading to positive lifestyle improvement.

d. Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment
The CMHOs are expected to use a single, standardized assessment tool approved by the State. Assessments based on other tools will not be accepted.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or nursing home.

Plan of Care
A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

Reporting
A complete listing of quality and monitoring measures is listed below. The State reserves the right to make modifications to required data elements and aggregate reports.

5. Assertive Community Treatment (ACT) and IHH Requirements

The requirements of ACT and IHH have several shared requirements but differ in the characteristics of the participants and the level of service intensity, as determined by the functional level score. ACT and IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.

Service Requirements
Participants are outreached by members of the ACT Team continually to engage in care to the maximum extent necessary to achieve individual goals. If a member refuses care or declines participation for ninety (90) days, the CMHO must notify the Contractor to review the Care Plan.

Participants are outreached and engaged by members of the IHH Team over the course of each month. The IHH Team members must be flexible and available to meet more frequently when needed. The IHH Team Leader is available 24 hours/day 7 days a week if needed.

The ACT and IHH Teams provides or coordinates the following services:

• Crisis Stabilization Services 24/7
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Medication Management Medication administration, monitoring and reconciliation
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Substance Use Treatment (for ACT participants only)
• Supported Employment/Schooling Assessment and Assistance
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Peer Support and IADL Support Services
• Education, Support, and Consultation to Clients' Families and Other Major Supports

A. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and the greater ACT/IHH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Stabilization

Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner.

These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service.

A. Therapy

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and response to treatment.

2. Individual and family Psychoeducation regarding mental illness and the effects and side effects of prescribed medications

3. Symptom-management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.

4. Individual, group and family supportive therapy

5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

B. Medication Prescription, Administration, Monitoring and Documentation

The ACT/IHH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

C. Dual Diagnosis Substance Use Disorder Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client-determined goals. This will be provided by an addiction specialist and include but is not be limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)

2. Assessment (e.g., stage of readiness to change, client-determined problem identification)

3. Motivational enhancement (e.g., developing discrepancies, psych education)

4. Active treatment (e.g., cognitive skills training, community reinforcement)

5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

D. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.

b. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

c. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.

d. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.

e. On-the-job or work-related crisis intervention.

f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

g. Job Development

h. On-site supports as needed

i. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)

j. Job coaching

E. Activities of Daily Living/ADL's

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

a. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)

b. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

c. Carry out personal hygiene and grooming tasks, as needed

d. Develop or improve money-management skills

e. Use available transportation

f. Have and effectively use a personal physician and dentist

F. Natural Supports and Social/Interpersonal Relationship Identification

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support required to:

a. Improve communication skills, develop assertiveness, and increase self-esteem

b. Develop social skills, increase social experiences, and develop meaningful personal relationships

c. Plan appropriate and productive use of leisure time

d. Relate to landlords, neighbors, and others effectively

e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

G. Peer Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self- imposed stigma. Services include:

1. Peer counseling and support

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

H. Instrumental Activities of Daily Living Support Services (IADL)

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and Dental services

2. Safe, clean, affordable housing

3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)

4. Social services

5. Transportation

6. Legal advocacy and representation

I. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1) Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process

2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people

3) Ongoing communication and collaboration, face-to-face and by telephone, between the ACT/IHH team and the family

4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery

5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

   a) Services to help clients throughout pregnancy and the birth of a child
   b) Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
   c) Services to help clients restore relationships with children who are not in the client's care and custody

J. Care Transitions

The ACT/IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

2. Upon hospital discharge (phone calls or home visit):

   - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.

- Assist consumer to identify key questions or concerns.
- Ensure the client understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent worsening of health conditions and facilitate the scheduling of all follow-up appointments.
- Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.

3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The Team Lead for an ACT team must be a licensed clinician. The Team Lead for an IHH team can be licensed as a Registered Nurse or have a Master's in Social Work. The assignment of the appropriate type of Lead CM is based on the level member's level of needs. In addition to the Team Lead, the ACT Team and IHH teams are expected to have a staff as defined in the *IHH Provider Manual.*

Reimbursement Arrangement
The provider is reimbursed based on a bundled rate for their ACT or IHH participants and MCO Fee for Service for selected services.

Billing for ACT will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the MCOs for MCO clients and for the State for Medicaid FFS clients. If a service provided for in the bundle is billed separately from the bundle, by the ACT provider or another provider, the claim will deny.

Individuals involved in the MHPRR program are not able to enroll in ACT. ACT billing is not allowed for persons in institutionalized settings. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

Billing for IHH will consist of the specified IHH code as well as other clinical services provided apart from the bundle. The IHH bundled rate is for care coordination activities only and does not include any clinical services. IHH can be billed while an individual is in an institutionalized setting. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

ACT Bundled Services	ACT MCO Fee for Service
• Crisis Stabilization Services including 24/7 access	• Clubhouse
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports	• Methadone
• Recovery& Rehabilitation skills	
• Supported Employment/Schooling assessment and assistance	
• Case Management- Identification and engagement of natural supports and Social relationships	
• Care Coordination- Outreach and engagement • Medical and Substance Use Treatment Coordination Activities	
• Team Rounding	
• Peer Support and IADL Support Services	
• Care Transition – hospital, incarceration or nursing home to home	
• Outpatient Clinical services provided at the CMHO including: Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy	
• Medication management including reconciliation	
• Substance Use Treatment (for ACT participants only)	

In general, the IHH program billing will encompass:

• Crisis Stabilization Services including 24/7 access	• Residential Treatment • Substance Use Treatment
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports	• Outpatient Clinical services provided at the CMHO and in community- Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy
• Recovery& Rehabilitation skills	• Clubhouse

• Case Management- Identification and engagement of natural supports and Social relationships	• Supported Employment/Schooling assessment and assistance

• Care Coordination-Care Transition – hospital, incarceration or nursing home to home	
• Medical and Substance Use Treatment Coordination Activities	
• Team Rounding	
• Care Transition – hospital, incarceration or nursing home to home	

Contractor Responsibility:
The Contractors will support the following:

- Provide CMHOs with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with CMHOs.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the CMHOs with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements as specified by EOHHS.
- The Contractor will adhere to a quality performance payment methodology and process that could include recoupments or withholds, as specified by EOHHS.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor will hold the member harmless.
- The Contractor will ensure that the CMHO's are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.

Integration with Rehabilitation Practices

Additional services not mentioned above for ACT/ IHH will integrate clinical treatment, services, and Rehabilitation practices including:

- Integrated Dual Diagnosis Treatment (substance use and mental illness), an evidence-based practice
- Mental Health Psychiatric Rehabilitation Residences (MHPRR)

Value-based Purchasing & Monitoring
The Contractor will adhere to a quality performance payment methodology and process that may include recoupments or withholds, as specified by EOHHS.

The information collected from each measure will be used for program monitoring and must be provided based on the parameters. These measures will be routinely reviewed and modified, based on industry trends.

6. In Plan Benefits

1. MENTAL HEALTH AND SUBSTANCE USE SERVICES

The Contractor commits to providing all Medicaid managed care adults a full continuum of mental health and substance use services. The Contractor's services will address all levels of need. The Contractor will have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community-based providers. All services should be provided to any adult member, as needed.

Services are not restricted to a specific pay level or category (such as an SPMI designation). The following provides an example of services that a CMHC or equivalent provider should provide. These include but are not limited to:

A. ACUTE SERVICES:
Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Emergency Service Intervention:**

24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment.

- The discharge plan will be shared with the member's physician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.

- The Contractor must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

- Alcohol Related Disorders
- Anxiety Disorders
- Mood Disorders

2. **Observation/Crisis Stabilization/Holding Bed:**

A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation and treatment in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

3. **Inpatient Acute Hospitalization:**

Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

4. **Acute Residential Treatment:**

A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and

group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, and 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

B. INTERMEDIATE SERVICES and OUTPATIENT

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. Partial Hospitalization (PHP):

A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For adults, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the adult's symptoms improve and a transition plan effectively transitions the adult back to the community, the PHP consults and coordinates the member's care with other treating providers, and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least 20 hours per week for BH and/or SUD

- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
- The Contractor will be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

2. Day/Evening Treatment:

A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Adults who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

3. Intensive Outpatient Treatment (IOP):

A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.

- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.

4. ACT & IHH:

Integrative behavioral and physical health care management model. Assessment, evaluation to identify member's behavioral and physical health needs. Care plan developed based on members identified needs with the goal of client stability and long-term community tenure. Coordination through regular contact and correspondence with primary care, social support, family, and treatment providers the member is involved with. Assist member in accessing social supports, vocational training and support, medical and behavioral health treatment, education training and support as identified through members' assessment and care plan. Case Manager must assist a member with transition from any 24-hour level of care or to prevent an admission. Case Management is delivered by adequately trained agency staff in accordance with applicable program specifications, State certification or licensing requirements, in addition to applicable MCO credentialing requirements.

The Contractor will reimburse these services in a manner defined by the State.

5. Peer Support/Recovery Coach:

A personal guide and mentor for people seeking or in recovery. The peer support/Recovery Coach assists to remove barriers and obstacles and links the recovering person to the recovery activities and supports.

6. Clubhouse:

The Clubhouse International model has been recognized by SAMHSA as an Evidence Base Practice for those with severe and persistent mental illness. Clubhouse has community structure, evidence-based practice, led by peers, recovery model with a focus on employment, wellness, and development of a community support network.

The Contractor will reimburse these services in a manner defined by the State.

Clubhouse services should include a minimum of three (3) hours per service, at least 1 time per week. At a program level, twenty-five percent (25%) of all members in the program must have an employment outcome of either supported employment, transitional employment or independent employment.

7. Integrated Dual Diagnosis Treatment for Substance Use Disorders:

Care management services provided in accordance with an approved treatment plan to ensure members with primary substance use maintain and build stability, recovery capital, and continued community tenure.

8. General Outpatient:

Clinical services inclusive of individual, group, family, crisis intervention, diagnostic evaluation, psychological testing, and medication evaluation and management. Treatment can be conducted in an office, home-based or community setting. Member has access to full continuum of Behavioral Health and Substance Use benefits offered by the Contractor (PHP, IOP, etc.) Clinical services are delivered by adequately trained behavioral health professionals in accordance with applicable program specifications and State licensing requirements.

9. Center of Excellence Program (COE):

Through the work of the Governor's Opioid Overdoes Prevention and Intervention Task Force, BHDDH will certify providers that meet the established COE certification standards. EOHHS will work with CODAC, and future providers who become certified, to ensure that proper arrangements are in place to allow COE providers to bill medication via J-codes or other methods that will allow them to dispense medication to members at their facility rather than prescribe to the member for self-management, under a point of sale system.

The program is reimbursed by fee for service for managed care members, with the exception of the medications (table or films) which is currently in the formulary of the Contractor and is a benefit for their members.

C. LONG TERM RESIDENTIAL PROGRAMS

Long Term SUD Residential Services:

The Contractor is required to contract with and support the SSTAR Birth Residential Program. This requirement includes but is not limited to a minimum six (6) month length of stay for the family unit. EOHHS reserves the right to review and approve any prior authorization process required by the Contractor.

Services must meet ASAM Level 3.5, Level 3.3, or 3.1

A. ASAM Level 3.5 Clinically Managed High- Intensity Residential:
Level 3.5 provides a structured, therapeutic community environment focused on addressing member life skills, reintegration into the community, employment, education, and recovery.

Minimum Requirements:

- Member meets at least all 3.5 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least12 clinical services per week including individual, group, & family, based on the member's need.

B. ASAM Level 3.3 Short- Term Clinically Managed- Medium Intensity:

Level 3.3 is a non- acute residential level of care that focuses on member stabilization, integration, employment, education, and recovery. A component of member treatment may focus on habilitation due to immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying to discharge from institutional level of care).

Minimum Requirements:

- Member meets all 3.3 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least12 clinical services per week including individual, group, & family, based on the member's need.

C. ASAM Level 3.1 Clinically Managed Low- Intensity Residential Services:

Minimum Requirements:

- Member meets at all 3.1 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 5 clinical services (1 hour per week of clinical treatment and 4 group and/or family sessions) per week including individual, group, & family, based on the member's need.

Mental Health Psychiatric Rehabilitative Residential (Group Home and Supportive Housing)

A Mental Health Psychiatric Rehabilitative Residence (MHPRR): is a licensed residential program that provides 24-hour staffing for a sub-population of the Integrated Health Home clients.

A physician must authorize all MHPRR services.

The "24-hour staffing" requirement means that the Provider must provide staff coverage 24 hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff is on site for these programs.

The service elements offered by a residential program include to the following based on each resident's individualized recovery-focused treatment plan:

- Mental health therapeutic and rehabilitative services for the resident to attain recovery
- Medication prescription, administration, education, cueing and monitoring
- Educational activities (appropriate to age and need)
- Menu planning, meal preparation and nutrition education
- Skill training regarding health and hygiene
- Budgeting skills training and/or assistance

- Community and daily living skills training
- Community resource information and access
- Transportation
- Social skills training and assistance in developing natural social support networks
- Cultural/Spiritual Activities
- Limited temporary physical assistance, as appropriate

In addition, each residential program provides the following for its residents:

- A homelike and comfortable setting
- Opportunities to participate in activities not provided within the residential setting
- Regular meetings between the residents and program personnel
- A daily schedule of activities
- Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age.
- Provisions for external smoking areas, quiet areas, and areas for personal visits

Supervised Apartments: A Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A) is a licensed residential program which provides 24-hour staffing for IHH clients in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services. Beds may be designated as Intensive, Specialty, Basic, Crisis/Respite, or any combination thereof.

Specific services may include, <u>but are not limited to:</u>

a) Medication: Education, administration and monitoring;

b) Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized treatment planning and skill teaching; income maintenance; and medical care assistance

c) Limited physical assistance as required: Mobility; assistance with non-injectable medications; dressing; range-of-motion exercises; transportation; and household services;

d) Skill assessment and development: Personal hygiene; health care needs; medication compliance; use of community resources; social skills development and assistance; support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized community activities.

The "24-hour staffing" requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff will be on site. Due to the complexity of these populations, staffing ratios are expected to be greater than traditional MHPRR settings. In addition, group home rules and expectations, levels of supervision and unaccompanied off-site travel will be specifically designed to address the needs of the population.

Target Population:

Services are for adults with complex mental illness who are stable and require specialized rehabilitation services versus basic MHPRR services, in order to continue on their recovery journey. Need indicators for placement will be based on:

- History of Risk of harm to self to others
- Unpredictable behavior and likelihood of relapse
- Motivation and capacity in the areas of self-management
- Socialization
- Mental Health Court Order for residential services.

The Contractor will reimburse MHPRR facilities at a rate defined by EOHHS.

Quality/Outcome:

Through chart audits at the CMHC, members in MHPRR should routinely attend all care management and integrated BH and medical services.

I. LEVEL OF CARE CRITERIA BASED UPON MEDICAL NECESSITY

The Contractor will provide descriptions of services and treatment settings. The criteria for medical necessity must be compliant with the medical necessity definition contained in Section 1.74 of the Contract and include admission, continuing stay and discharge criteria for each.

II. EARLY IDENTIFICATION AND ACCESS

The Contractor will have defined methods to promote access to care and for early identification of adults with behavioral health needs, including:

1. Identification of members who may be in an inpatient setting and who will require intensive outpatient services following and to facilitate discharge,
2. Direct referral by a family member or other health care provider.

III. ACCESSIBILITY, AVAILABILITY, REFERRAL AND TRIAGE

The behavioral health program will have defined performance criteria for accessibility, availability, referral and triage that meet and/or-exceed NCQA standards.

IV. PROVIDER NETWORK AND NETWORK ADEQUACY

The Contractor will develop and monitor behavioral health provider network standards, subject to review by the Department, to ensure the full continuum of behavioral health needs is met on a timely basis and to promote geographic accessibility.

V. TRANSITION PLAN

1. The Contractor is required to honor all prior authorizations for the period of the

authorization and with the provider authorized.

2. The Contractor will complete a readiness process approved by the state prior to IHH program implementation
3. The Contractor will complete a review and identify and report to EOHHS on:
    a. IHH
    b. ACT
    c. A Community Health Team (CHT)
    d. Patient Medical Centered Medical Home (PCMH)

The Opioid Treatment Program Health Home Program Description
The following provides a description of the Opioid Treatment Program Health Home (OTP HH). These services are specific to individuals with opiate dependence disorders who have or are at risk of chronic physical illnesses. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

The Opioid Treatment Program Health Home Program
The Opioid Treatment Program (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination, monitor chronic conditions, enhance coordination of physical care and treatment for opioid dependence, and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person-centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers.

OTP Health Home(s): as the fixed point of responsibility to coordinate and ensure the delivery of **person-centered care,** the OTP Health home staff ensure and provide timely post discharge follow-up and coordination with other behavioral health providers and primary care providers in the delivery of medical services to the member. The OTP Health Home places emphasis on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and better alignment with standards of care for chronic medical conditions such as Hepatitis C, HIV, Diabetes, Asthma, and COPD.

Patient Eligibility
Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Provider Eligibility
The Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) licenses Opiate Treatment Programs and OTP Health Homes.

2. Goals of OTP HH

The specialized programs for adults with opioid dependence and co-occurring chronic conditions or risk of chronic conditions will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This OTP Health Home program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	• Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	• Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	• Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Program Description

Patient Eligibility

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Core Functions and Responsibilities of OTP Health Home Providers

The OTP Health Homes will carry out the following functions:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the BHDDH-approved OTP Eligibility Checklist form. Based on the finding on the checklist and a bio-psychosocial assessment, the provider will determine and place the individual in the OTP Health Home. Develop a person-centered, individualized Care Plan
- Carry out treatment and recovery services in the OTP Health Home OTP HH model of care
- Actively use CurrentCare for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the CurrentCare program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Submit required metric reporting and data exchange to the Health Home Administrative Coordinator
- Coordinate with the Integrated Health Home and ACT program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, OTP HH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the OTP Health Home's ability to provide the services required for OTP Health Home OTP HH within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The OTP Health Home is a OTP HH specialized program that uses a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. The OTP HH model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from addiction and lead healthier lives and manage their other chronic conditions. Active treatment and supports are provided with cultural competence.

Program Definitions

The OTP Health Home services are defined below:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The OTP Health Home (OTP HH) is built upon the evidence-based practices of the patient-centered medical home model. The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses. OTP Health Home is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. OTP Health Home uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

OTP HH activities are focused in four areas:

1. Care coordination and health promotion

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, the primary care manager will collaborate with primary and specialty care providers as required and provide education about medications (e.g. educating through written materials, etc.). The OTP Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. Chronic condition management and population management

The OTP HHOTP HH team supports its consumers as they participate in managing the care they receive. Interventions provided under OTP HH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their opiate addictions and their life situations;

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of their opiate addiction and other chronic medical illnesses as advised by the client's primary/specialty medical team.

- Assisting the client in locating and effectively utilizing all necessary community services to address the client's medical, social and psychiatric needs and ensuring that services provided are coordinated with those provided through physical health care professionals;

- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to address their symptoms of addiction. Activities include:

- Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).

- Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

- The OTP HH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps OTP HH's improve their care delivery system, to the benefit of each OTP HH clients receiving care.

3. Comprehensive transitional care

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The OTP HH team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.

- Assist consumer to identify key questions or concerns.
- Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow-up appointments.
- Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Review with the OTP HH team transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to OTP HH consumers – to clarify all outstanding questions.
- Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

OTP HH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized substance use education about the client's opiate addiction and other chronic illnesses and the role of the family and their significant people in the therapeutic process.

OTP HH recovery support specialists will help OTP HH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Recovery support serves will validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

- Help clients establish a link to primary health care and health promotion activities.
- Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.
- Assist clients in making behavioral changes leading to positive lifestyle improvement.
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment

The OTP Health Home Providers will use the BHDDH-designed checklist to assess clients' needs for OTP Health homes.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or detoxification program.

Plan of Care

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

5. OTP HH Reporting Requirements

The OTP HH Reporting Requirements are managed by the OTP Health Home Administrator and coordinated with BHDDH and the OTP HH providers. All reports must be submitted to EOHHS at a frequency defined by EOHHS.

6. Service Delivery and Coordination

The OTP HH Teams provide or coordinate the following services:

• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Education, Support, and Consultation to Clients' Families and Other Major Supports

7. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and other members of the OTP HH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

8. Therapy

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's opiate addiction and response to treatment.
2. Individual and family education regarding opiate addiction and the effects and side effects of prescribed medications
3. Addiction management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her opiate addiction and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

9. Medication Prescription, Administration, Monitoring and Documentation

The OTP HH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

10. Contractor Responsibilities

The Contractor is responsible for offering contracts to all EOHHS specified OTP HH providers. The Contractor will pay a specified rate to each provider for OTP HH services as directed by the EOHHS. The Contractor is responsible for following all guidance material distributed by EOHHS relating to this program, including the *OTP HH Billing Manual.* The Contractor will not pay less than currently established rates but may bundle of provide global rates, with the approval of EOHHS."

11. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
2. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance

and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
4. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
5. On-the-job or work-related crisis intervention.
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
7. Job Development
8. On-site supports as needed
9. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
10. Job coaching

12. Ensuring Safe and Stable Housing

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

13. Natural Supports and Social/Interpersonal Relationship Identification

Provide opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

14. Recovery Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery.

1. Recovery counseling and support
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

15. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's opiate addiction and chronic illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the OTP HH team and the family
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
   a. Services to help clients throughout pregnancy and the birth of a child
   b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
   c. Services to help clients restore relationships with children who are not in the client's care and custody

16. Care Transitions

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
   - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.

- Assist consumer to identify key questions or concerns.
- Ensure the client understands medications, their potential side-effects, is knowledgeable about indications if their condition is worsening and how to respond and is educated on how to prevent worsening of health conditions.
- Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.

3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The OTP Health Home staff is made up of the following multi-disciplinary complement of staff:

- The OTP Health Home team staff composition required to provide services, based on a population of one hundred twenty-five patients (125) per team, is outlined below. *Any deviation from that staffing pattern will require a written proposal to the Department for approval that includes clinical and financial justification.*

Qualifications:	**Health Home FTE***
Master's Level Team Coordinator	1.0
Physician	0.25
Registered Nurse	1.0
Case Manager – Hospital/Healthcare Liaison	1.0
Case Manager	1.0
Pharmacist	0.10
Total Personnel	**4.35**

Reimbursement Arrangement
The provider is reimbursed based on a bundled rate for their OTP HH participants.

Billing for OTP Health Home will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the Contractor for MCO clients and for the State for Medicaid FFS clients.

Billing for OTP HH will consist of the specified OTP HH code as well as other clinical services provided apart from the bundle. The OTP HH bundled rate is for care coordination activities only and does not include any clinical services or Medication Assistance Treatment (MAT) services. OTP HH can be billed while an individual is in an institutionalized setting. Refer to the *OTP HH Program Description* for detailed information on billing.

Contractor Responsibility:

The Contractors will support the following:

- Provide OTP Health with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the OTP Health Homes with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements based on a reporting calendar.
- The Contractor will adhere to the withhold payout requirements based on a reporting calendar.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor will hold the member harmless.

The Contractor will ensure that the OTP Health Homes are submitting HIPAA compliant claims data for services delivered under the OTP HH and ACT bundles.

ATTACHMENT Q

CARE MANAGEMENT PROTOCOLS FOR ALL MEMBERS

The overriding goal of the State is to provide eligible members access to quality services and supports tailored to their needs that maximize their health care status, promote their independence, and maintain their quality of life in the most cost-effective manner. To this end, the Contractor will be required to develop and maintain policies and procedures directed at this goal that are approved by EOHHS. The Contractor will comply with all State and Federal legal, administrative and programmatic requirements related to these programs and adhere to the provisions of the Contract.

1. INTRODUCTION

Health Plans are required to comply with EOHHS Care Management Protocols for members covered under this Agreement. The Contractor will have a care management strategy inclusive of a program description and established policies and procedures that set forth the Contractor's approach to compliance. This will include policies, procedures and criteria/content for identifying and defining those at risk, conducting Health Risk Assessments and for providing Short-Term care coordination and Intensive Care Management Services. The Contractor's policies and procedures are subject to review and approval by EOHHS.

In addition to specific health needs, these enrollees and their families, guardians, or adult caretakers may need special assistance in accessing needed services, inclusive of behavioral health, and other community and social supports and services.

The level and type of assistance needed by members and their families, guardians, and adult caretakers will vary considerably. For many members, enrollment into the Health Plan and the ability to access the plan's existing resources will be sufficient. For others, assistance and support may be needed to meet immediate service delivery needs for continuity of care or accessing services. For others, more intensive needs may be present, calling for a more intensive review of needs and care management.

A primary focus of the Health Plan's Care Management program will be:

2.16.04 To identify members with significant health and social needs that are at high risk of poor health outcomes who may require care management services, such as children with special health care needs and individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged form correctional facilities.

2.16.05 To employ the use of predictive modeling tool and analytic to continually identify member at risk for becoming high risk or high utilizers.

2.16.06 To provide Short Term care coordination or Intensive Care Management to those requiring these services.

2.16.07 To engage and empower members in the process

2.16.08 To work in conjunction with community and practice-based care management

providers to avoid duplication of effort and services

2.16.09 To identify member strengths and preferences as well as risks which may affect the outcomes of the member

The Care Management program will serve as a continuing resource to members as circumstances and needs change. Where possible, continuity in relationships with Care Managers will be preserved by the Contractor, especially when a member has an established relationship with a practice and/or community case or care management provider such as a medical home, health home, or community health team.

2. CORE CARE MANAGEMENT PROGRAM COMPONENTS

The Care Management program will include the following core components:

Health Risk Assessment
Short Term Care Coordination
Intensive Care Management

2.1 Health Risk Assessment

A Health Risk Assessment will be completed for all members through contact with the member or the member's family, guardian or adult caregiver. Contact can be either telephonic or in-person by a care manager or care coordinator from the Health Plan and/or from an accountable entity provider such as a medical home, health home or community health team. This screen is intended to identify adults and children with needs that call for further action within the Care Management program. As such, the Contractor will assess and determine the need for a face to face encounter with the member as part of its process to engage the member in a care management program and/or other intervention or program as appropriate.

Purpose

The primary purpose of the Health Risk Assessment is to:

- Identify members who are at risk of poor outcomes and/or who may require more intensive care management activities.
- Identify immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying providers).

- To introduce members to the assistance provided by care management either by the Health Plan and /or an established provider or community care manager.
- Assist all members in improving health outcomes.
- Trigger next steps, where indicated.

On the basis of the Health Risk Assessment, it will be determined that an individual fits in one of the following categories:

- Health Maintenance Focus. This pertains to members who are not in current need of further assistance to meet current service delivery needs and do not need more comprehensive coordination or more intensive care management activities, but for whom maintenance of current health status, independence, and self-management, and prevention of further disability and/or chronic disease should be a priority. It may also identify those areas of strength, which if lost or altered could require the initiation of additional supports or services.
- Further Action Required. In such cases, potential needs have been identified and further follow up is indicated either with care coordination and/or Intensive Care Management (see descriptions of each below).

Scope

The Health Risk Assessment conducted by the Health Plan and/or its delegated accountable entity, medical home, health home, or community health team must identify adults who have transition of care needs and who may benefit from care management services:

- The Health Risk Assessment will have an interdisciplinary, holistic, preventive health and strength-based focus, and screen for medical/physical needs, behavioral health needs, functional, social and financial issues with an aim of maximizing independence and functioning.
- The Screen will identify and meet specific linguistic and cultural needs and address any barriers to care.
- The Screen must identify needs for continuity of care and assistance in securing appointments/procedures, prior authorizations, medications, hospitalizations, or other benefits; satisfaction with PCP selection; determination of current use of out-of-network providers; and current involvement with a specialist who may serve as a principal coordinating physician for that member.
- The Screen will identify member's risk factors that may indicate potential need for care management. These must include but are not limited to:

- Perceived health status
- Behavioral health and substance use status
- Sense of being overwhelmed by their condition and how to navigate the health care system, inclusive of potential linguistic or social barriers
- Social determinants of care
- Medical status and history, including primary and secondary diagnosis, Health maintenance-preventive and chronic care management, and oral health
- Utilization of prescription medications
- Excess inpatient hospital, emergency EOHHS and prescription medication utilization that would indicate someone who is at high risk. Service use that is above that which would be considered usual or routine
- Complexity and intensity of care needs (e.g. related to acuity, duration, frequency of exacerbations and service needs, multiple diagnoses)
- Recognition of existing and potential formal and informal supports, including peer supports as well as caregiver burden
- Determination of willingness and capacity of family members or, where applicable, authorized persons and others to provide informal support
- Involvement or need for involvement with multiple providers, multiple therapies, other service systems (e.g. MHRH, DEA, etc.) and community agencies.
- Functional or environmental limitations or deficits, e.g. activities of daily living, mobility
- Stability of the home setting and ability of the member or their designee to process information, make decisions, coordinate services and advocate for themselves (e.g. related to resources, skills, time constraints, competing demands, health needs and problems of other family members
- Requirements for specialized therapies, medical supplies or DME
- Condition and proximity to services of current housing, and access to appropriate transportation
- Identification of current or potential long-term service needs
- Transitions from adolescence to adulthood
- Advance care planning

Timeliness

The Contractor and will in collaboration with delegated entity such as an accountable entity, medical home, health home or community health team conduct a Health Risk Assessment of new members who have not been enrolled in the prior twelve (12) month period. The Health Risk Assessment must be completed for all members within ninety (90) days of the of the member's enrollment with the Contractor or within ninety (90) days of the member's twenty-first (21) birthday. In the initial start-up period, The Health Plan has one-hundred and eighty (180) days to conduct the Health Risk Assessment of members who become eligible at the beginning of the contract start-up period. The Contractor will make at minimum three outreach attempts to contact each member.

The contractor agrees to make all reasonable efforts to engage new members in person by telephone, mail, and/or online to have the member complete the Health Risk Assessment. Health Risk Assessment completed by a provider or community case management within the last twelve (12) month can be utilized to inform the completion of the Health Risk Assessment.

Qualified Staff

Appropriately trained non-licensed or licensed personnel may perform Health Risk Assessment. Where performed by non-licensed personnel, the Health Plan will establish appropriate qualifications requirements (including education, experience, and training) for these performing personnel to assure that these activities are effectively carried out; such activity will be under the direct supervision and oversight of a Care Manager who meets the licensure requirements as set forth herein. Non-licensed or licensed personnel may perform Short Term Care Management activities. Members will be offered assistance in arranging an initial visit to their provider for a baseline assessment and other preventive services, including an assessment of the member potential risk, if any, for specific disease or condition.

Health Risk Assessment

Purpose

The Health Risk Assessment has two primary purposes. The first is to determine specific needs for access to services and/or continuity of care that would dictate the content and objectives of care coordination; and/or the second is to determine the presence of risk factors for the member that would indicate the need for a more intensive care management.

Regarding coordination of services and continuity of care, the Health Risk Assessment will examine the circumstances of the member that need to be addressed from a care coordination perspective. These can include, for example: current involvement with a regimen of care for which prior authorization is required for continued service; difficulties in identifying or gaining access to specific types of providers to meet needs; support in transitioning from pediatric to adult health care; changes that have occurred or are occurring in independent living; changes in service arrangements with medical or non-medical services that may accompany the transition to adulthood; current involvements with an out of network provider and the need for arrangements to ensure continuity; dependence on medications or medical equipment or supplies.

Care Coordination is expected to require limited focused effort and consists of those actions necessary to work on behalf of members to address identified information needs and referrals, coordination of services, access and continuity of care needs.

Identification of risk: The Health Risk Assessment must differentiate between members for whom care coordination is sufficient and for whom a more intensive level of care management and support may be necessary to:

- Prevent detrimental change in the member's health status
- Maintain the member's ability to live in the community
- Avoid acute episodes of hospitalization or institutionalization

Cases where a more intensive level of review may be necessary can include:

- Members who have complex conditions that may require multiple services.
- Households where the caregivers have limited knowledge and ability to advocate for and facilitate the care for the member.
- Circumstances where the member is overwhelmed or is at risk of being overwhelmed by their circumstances and needs and face considerable difficulty self-managing their condition.

2.2 Intensive Care Management Plan

It is anticipated that for the majority of members moving beyond the Health Risk Assessment, care coordination will be sufficient. Where indicated or requested by the member or family, an Intensive Care Management plan is to be developed based on the Health Risk Assessment.

The Intensive Care Management Plan is a person driven plan developed for members at risk. It will be developed and ideally led by the member in collaboration with the member's provider (medical or behavioral health), the member's family, guardian or caregiver; home and community-based waiver provider or case worker, and other public and private providers and agencies if applicable. The Plan will include:

- Identification of key issues for the member as determined in the Health Risk Assessment.
- Identification of all medically necessary services and Health Plan actions appropriate to
- Prevent detrimental change in the condition(s) and to promote the development or maintenance of appropriate functioning by the member. This includes behavioral health services and social supports and services.
-
- Involve members and their families in setting goals, objectives, and action steps and identifying priorities to address member issues.
- Goals for the enrollee which include self-management, appropriate use of resources, ability to identify their own triggers and the ability to use the health care system effectively (e.g. keeping appointments)

Health Plans must identify out of plan items and services and take action appropriate to prevent decrement change in the member's condition(s) and to promote the development or maintenance of appropriate functioning by the member. Services include: behavioral health services; health education and social support services that are indicated for the member or a caregiver, and coordination with home and community-based waiver providers.

It is the preference of the EOHHS that this be accomplished in collaboration with medical homes, health homes, community health team and home and community-based waiver service provider, if applicable, to effectively coordinate care, identify roles and responsibilities and avoid duplication of services

Communication with member

The Health Plan must ensure that Intensive Care Management Plans, in the case of an enrolled adult upon request are promptly made available to the member, guardian, or adult caregiver. The Health Plan will inform all members that they are entitled to request a written or electronic copy of the Intensive Care Management Plan.

3. ADDITIONAL REQUIREMENTS

3.1 Record Keeping Regarding Core Components of Care Management

The Health Plan will maintain records to identify completion of Health Risk Assessment, care coordination, and Intensive Care Management. For all members receiving intensive care managements, records will include the resulting Intensive Care Management Plan or documentation of why such a plan is not needed.

3.2 Designation of a Program Coordinator (Care Manager)

The Health Plan will designate a Program Coordinator (and/or Care Manager). The Care Manager will be a licensed professional who will assure that the Health Risk Assessment, care coordination or Intensive Care Plan development and implementation, as indicated, are completed for each member. The Care Manager must meet the licensure requirements as set forth herein. The responsibilities of the Care Manager will be inclusive of behavioral health services and social supports and services.

3.3 Continuing Care Management for Members and Families

Core Care Management components as described above are focused primarily on new adult enrollees. The Care Manager and care management staff will also be a resource for members, their guardians, caretakers' and providers in accessing needed services and Care Management components as such needs arise during the course of enrollment with the Health Plan. Members and families are to be provided with written information as to how they can access the Health Plan's care management program at any time.

3.4 Health Plan Policies and Procedures

- The Health Plan will have a written program description and Policies and Procedures that delineate compliance with these Care Management Protocols for members covered under his Agreement. The Health Plan's policies and procedures are subject to review and

approval by the EOHHS. The following elements should be included in the Health Plan policies and procedures: Written description of the activities and responsibilities that are part of the care management process, including procedures for monitoring the coordination of care provided, including but not limited to medically necessary services delivered in and out of the Health Plan's provider network.

- Process of demonstrating shared decision making with the member, inclusive of member attestation or signature of a care management plan, if applicable.

- Annual review and evaluation of the program description with approval by the Health Plans' governing body or authorized designee.

- Process for obtaining input into the development of the Health Plan's care management program and annual evaluation, including input from members (and families/caregivers as appropriate with written or verbal consent) and providers.

- Process for completing Health Risk Assessments

- Process for review/approval of assessment tools by EOHHS.

- Standardized procedures/description/methodology for identifying members for care management, including a process for self-referral and regular review of utilization and claims data.

- Description of the qualifications of people who will act as care managers, the approach for having sufficient staff available/monitoring caseloads, and the appropriate methods for using a multi-disciplinary team.

- Description of the components of a care plan, including how it is developed and reviewed in collaboration with the members and other members of the members' care team.

- Process for collaborating with out-of-plan services, including but not limited to home and community-based waiver programs.

- Process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group (if applicable), inclusive of accountable entities and/or medical home, health home or community health team

- Process for obtaining member input on satisfaction with individual care manager services.

- Information systems to support monitoring/management of care plans, the care management program, communication, and information-sharing among care managers, providers, accountable entities, provider and community care managers

- Process to regularly update care plans based on changes in the member's medical or social

status.

- Process to obtain information on recommendations made by nurses staffing after- hours advice line (if applicable)

3.5 Care Management Staff Based in Rhode Island

Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island and may be augmented by Health Plan expertise located in other areas. Rhode Island staff will be key for their ability to work closely with local resources and communities including face- to-face meetings where appropriate, to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs and out- of-plan services. The Contractor's Program Coordinator (and/or Care Manager) and all their needed support staff will be located in Rhode Island. The Contractor should leverage existing provider and community-based care management resources in performing care management program requirements to ensure no duplication and may also delegate care management responsibilities to network providers including but not limited to patient-centered medical home providers, health homes and community health team. The Contractor must operationalize the lead care management process as outlined below.

3.6 Modification to Rhode Island EOHHS Protocols for Members

EOHHS reserves the right to amend these Care Management protocols from time to time, with reasonable notice to Health Plans.

3.7 Additional Provisions for Special Population Groups

3.07.01 Provisions for Members who are Active with a Ryan White non-- medical Case Management Agency

For those members whom are actively engaged with an AIDS Case Management Agency for non-medical case management, the Contractor will develop policies and procedures that support the AIDS Case Management Agency as the lead care manager for that member. The Contractor may employ predictive modeling tools to identify members who are newly infected with HIV, and develop protocols for referring and engaging them with an AIDS Case Management Agency.

3.07.02 Provisions for Members who are recently discharged from Corrections Facilities

The Contractor may modify the Health Risk Assessment (HRA) to seek information regarding incarceration history. For those members for whom a history of incarceration is known, the Contractor may incorporate a record of data from the EOHHS of Correction's Electronic Medical System in the members file or in the care management system.

For those members for whom a history of incarceration is known, the Contractor will coordinate with Reentry Council Agency to discuss and review the existing Plan of Care and new items identified

during HRA. Contact with the Reentry Council Agency will take place within thirty (30) days of notification to the Contractor that the member is engaged with the Reentry Council Agency.

3.07.03 Other Special Populations

The Contractor and EOHHS will work collaboratively with stakeholders during the start-up period to develop specialized care management programs and level of care criteria to determine utilization review requirements for special populations. These special populations include but are not limited to:

- Children with Special Health Care Needs
- People living with HIV and AIDS
- People with serious mental illness
- People with addiction issues
- People recently discharged form correctional facilities

Prior to the development of the specialized care management programs, the Contractor will coordinate services with the following providers and/or agencies:

- The RI EOHHS of Behavioral Health Developmental Disabilities and Hospitals (BHDDH)
- The RI EOHHS of Corrections
- AIDS Case Management Agencies

3.8 Planning for System Redesign and Transition

The Contractor will work collaboratively with EOHHS, BHDDH, and other stakeholders to integrate and transition behavioral health services into managed care.

Prior to the development of the specialized care management programs, the Contractor will coordinate services with the RI EOHHS of Behavioral Health Developmental Disabilities and Hospitals (BHDDH) and its licensed providers.

ATTACHMENT U

CLAIMS BASED DATA ELEMENTS

Claims Based Data Elements			
Field name/Description		**Source/field number**	
MEMBER FIELDS	**DESCRIPTION**	**1500****	**UB-04/CMS 1450**
Member ID ()	Payer defined, internal member id for subscriber ID and insurance product changes	Box 1a	Box 60
Insurance Product		Box 9d	Box 50
Subscriber ID		Box 4	Box 8a
Last Name		Box 2	Box 8b, 58, 60
First Name		Box 2	Box 8b, 58, 60
Middle Name		Box 2	Box 8b
DOB		Box 3	Box 10
Gender		Box 3	Box 11
SDOH	Any documented social determinants of health, for example, documented as Z-codes		
CLAIMS FIELDS		1500	UB-04
Claim Line ID	Unique claim identifier		
Claim Line Payment Status	Most up to date status of claim (as available)		
Claim Type	Code - usually a letter - that identifies the "general" type of claim (e.g., Outpatient, Inpatient, Dental, Professional)		
Paid Amount	Final amount that was paid by the plans for the services provided on the claim		
Payer Authorization ID		Box 23	
Date of Service		Box 24A	Box 45
Admission Date	Date of admission to a facility	Box 18	Box 12
Discharge Date	Date of physical discharge to community or other facility (e.g., rehab, nursing home)	Box 18	Box 6
From Date	Date of which the services where provided	Box 24A	Box 6
Thru Date		Box 24A	Box 6
Days	Represents Length of Stay for applicable claims		
Effective Date		Box 24A	

Claims Based Data Elements			
Field name/Description		**Source/field number**	
Line Number/ Line ID (including unique claim ID and data definition)	Claim Detail number	Box 24A	
Line From Date	First Date of which the services where provided	Box 24A	
Line Thru Date	Last date of which the services were provided		
Facility Type			Box 4
Place of Service Code	Code that describes the type of place or facility for which the service occurred (e.g., Federally Qualified Health Center, Urgent Care Facility)		
Outpatient Type			Box 4
Admission Flag			Box 66A
Readmission Flag			
Admission Type	Urgent, elective, etc.		Box 14
Revenue Code	4-digit numbers that are used on bills/claims to tell the insurance companies either where the patient was when they received treatment, or what type of item a patient might have received as a patient.		Box 42
Discharge Status Code	Status code describing where the patient was discharged to		
Discharge Status Description	Description of the discharge status code		
Type of Bill Code	Identifies the type of bill being submitted to a payer		Box 4
Paid Date	Date of which the services on the claim were paid by the plans		
Facility Name	The name of the facility where services were rendered	Box 32	Box 1
Rendering Provider NPI	Also referred to as "Attending Provider"; the National Provider Identifier who administers the service on the claim	Box 32 A	Box 56
Rendering Provider Name	Also referred to as "Attending Provider"; the name of the		Box 01

Claims Based Data Elements			
Field name/Description		**Source/field number**	
	Provider who administers the service on the claim		
Billing Provider NPI	The National Provider Identifier who bills for the service on the claim		
Billing Provider Name	The name of the provider or practice who bills for the service on the claim		
Billing Provider TIN	Employer Identification Number (EIN) /Taxpayer Identification Number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line item service		
Attributed PCP NPI	NPI of the member's attributed PCP, as part of the AE program		
Attributed PCP Name (Last)	Last name of the member's attributed PCP, as part of the AE program		
Attributed PCP Name (First)	First name of the member's attributed PCP, as part of the AE program		
IHH Name (if applicable)	Integrated Health Home that the member belongs to		
ICD Diagnosis Code(s)	International Classification of Diseases (ICD); provides a method of classifying diseases, injuries, and causes of death.		
ICD Diagnosis Version	identifies whether the type of ICD code is version 9 or 10		
CPT Code(s)	Current Procedural Terminology (CPT)/Procedure Codes; describes what kind of procedure a patient has received	Box 24D	Box 74a-e
Modifier Code(s)	Indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code.	Box 24D	
HCPCS Codes		Box 24D	
HCPCS Modifiers		Box 24D	

Claims Based Data Elements			
Field name/Description		**Source/field number**	
DRG Code	Diagnosis-related group (DRG); classifies cases according to certain groups, also referred to as DRGs, which are expected to have similar hospital resource use (cost)		Box 71
DRG Description	Describes the the type f DRG (e.g., heart failure, pneumonia, and hip/knee replacement).	Other	other
DRG Code Type {MS|AP|APR}	A more detailed breakdown of DRG classifications	Other	other
ICD Code(s)		Box 21A-L	Box 67
ICD Version {9|10}		Box 21 ICD INC	

Non-Claims Based Data Elements			
ELIGIBILITY FIELDS	**Description**	**other**	
Subscriber ID	Payer defined, internal member id for subscriber ID and insurance product changes		
Last Name			
First Name			
Middle Name			
DOB			
Gender			
Race			
Ethnicity			
Language			
Member Risk Score	Rolling 12 score or PY score at the time of eligibility month.		
Member Year	Year of eligibility		
Member Month {1..12}	Month of eligibility		
Member ID	Payer defined, internal member id		
Insurance Product	Name of insurance product (Medicaid, Medicare are examples)		
Subscriber ID	The National Provider Identifier who is the attending PCP on the claim		
PCP last name			
PCP first name			
PCP NPI			

IHH Name (if applicable)			
Member Risk Score			
RX FIELDS	Descriptions	other	
Prescriber NPI	The National Provider Identifier who prescribed the medication		
Drug Class	Describes medications that are grouped together because of their similarity.		
Drug Name	Referring to the chemical makeup of a drug rather than to the advertised brand name under which the drug is sold		
NDC Code	National Drug Code (NDC); a unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs		
Drug Type	{Generic|Brand|Specialty|Other}		
Dispense as Written Code	A code indicating whether or not the prescription was dispensed as written by the prescribing provider		
Days Supply	Number of days which the drug was prescribed to the patient		
Quantity Dispensed	Amount of prescription dispensed to patient		
Therapeutic Class	This type of categorization of drugs is from a medical perspective and categorizes them by the pathology they are used to treat.		
Filled Date	Date which the prescription was filled by patient		
Pharmacy Service Provider Name	Member's preferred pharmacy		

Individual level data files for AE Outcome Measures (to be generated by EOHHS)

File 1: Members Experiencing Mental Illness [MCO] [Time period].csv		
Field Description	**Field Name**	**Source**
Medicaid ID	MEDICAID_ID	AE population extract file
Member name	MEMBER_NAME	AE population extract file
Member Date of Birth	MEMBER_DOB	AE population extract file
Attributed AE	MEMBER_AE	AE population extract file
Attributed PCP	MEMBER_PCP	AE population extract file

File 2: Preventable ED Visits [MCO] [Time period].csv		
Field Description	**Field Name**	**Source**
Medicaid ID	MEDICAID_ID	AE population extract file
Member name	MEMBER_NAME	AE population extract file
Member Date of Birth	MEMBER_DOB	AE population extract file
Attributed AE	MEMBER_AE	AE population extract file
Attributed PCP	MEMBER_PCP	AE population extract file
Primary Diagnosis code	DIAG_CDE_1	MMIS
Probability visit was avoidable	PREVENT_PROB	MMIS + NYU algorithm
Date of service	FROM_SVC_DTE	MMIS
Billing provider NPI	BLNG_PR_NPI	MMIS
Claim ICN	CL_ICN	MMIS

ATTACHMENT V

COVID-19 PUBLIC HEALTH EMERGENCY

Contractor is required to follow policy memorandum and guidance and requirements from EOHHS and CMS related to easing restriction and/or reinstatement of restrictions related to the COVID-19 public health emergency.

The Contractor is required to support any Federal and State requirements around vaccinations for COVID-19. Contractor agrees to be paid a non-risk payment for the administration of an approved COVID-19 vaccine in an amount equal to the State's fee-for-service fee schedule. Contractor agrees to pay COVID-19 vaccine providers the specified rate for COVID vaccine administration and submit required documentation for non-risk payment reimbursement by EOHHS.

INDEX

State Guide to CMS Criteria for Managed Care Contract Review and Approval

[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. B. Enrollment and Disenrollment B.1. No Discrimination B.1.1.

[Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to accept new enrollment from individuals in the order in which they apply without restriction up to the limits set under the contract. [42 CFR 438.6 (d)(1)] B.1.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from discriminating against individuals eligible to enroll on the basis of health status or need for health care services. [42 CFR 438.6 (d) (3) and (4)] B.1.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from discriminating against, or using any policy or practice that has the effect of discriminating against, individuals eligible to enroll on the basis of race, color, or national origin. [42 CFR 438.6 (d) (3) and (4)] B.2 Choice of Doctor B.2.2. [Applies to MCO, PIHP, PAHP] The contract requires the MCE to allow each enrollee to choose his or her health professional to the extent possible and appropriate. [42 CFR 438.6(m)] B.3 Opt Out B.3.1. [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies procedures for enrollment and reenrollment. [42 CFR 438.6 (d)(2)] B.3.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that MCE enrollment is voluntary, except when CMS has approved federal authority allowing the state to mandate enrollment. [42 CFR 438.6 (d)(2)] B.6 Disenrollment Request Process B.6.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCE files the request. [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.6(k); 42 CFR 438.56(c)] B.6.4. [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that if the entity or State agency (whichever is responsible) fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the enrollee or the MCE files the request), the disenrollment is considered approved. [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.6(k); 42 CFR 438.56(c)]

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. C. Beneficiary Notification C.2 Enrollee Information C.2.17 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide adult enrollees with written information on advance directives polices, and include: (1) a description of applicable State law, (2) the MCE's advance directives policies, including a description of any limitations the MCE places on the implementation of advance directives as a matter of conscience, and (3) instructions that complaints concerning noncompliance with advance directives requirements may be filed with the state Survey & Certification agency. [42 CFR 438.6(i)(3); 42 CFR 438.6(i)(4); 42 CFR 438.10(g)(2); 42 CFR 438.10(h)(2)] C.2.18 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to reflect changes in State law in its written advance directives information as soon as possible, but no later than 90 days after the effective date of the change. [42 CFR 438.6(i)(4)] C.4 Passive Enrollment C.4.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies any procedures for Passive Enrollment including timelines associated with any "trial period" (where applicable). The contract specifies how the MCE ensures that enrollees are adequately notified of their enrollment. [42 CFR 438.6 (d) (2)]

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.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)] D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100] D.1.5 [Applies to PAHP] The contract requires that the MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the PAHP if the MCE's provider network includes: home health agencies, home health care providers, personal care providers or hospice providers. [42 CFR 438.6(i)(2); 42 CFR 438.10(h)] D.13 Provider Preventable Conditions D.13.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to report all identified provider-preventable conditions in a form or frequency, which may be specified by the State. [42 CFR 438.6(f)(2)(ii)]

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. E. Providers and Provider Network E.1 Network Adequacy E.1.1 [Applies to PCCM] The contract requires the MCE to provide reasonable hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions. [42 CFR 438.6(k)] E.1.2 [Applies to PCCM] The contract requires the MCE to make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the enrollees are getting the services provided for under the contract, promptly and without compromising the quality of care. [42 CFR 438.6(k)(3)] E.1.11 [Applies to PCCM] The contract restricts enrollment to recipients who reside sufficiently near one of the PCCM provider sites to reach that site within a reasonable time using available and affordable modes of transportation. [42 CFR 438.6(k)] E.7 Balance Billing E.7.1 [Applies to MCO, PIHP, PAHP] The contract obligates the MCE to require that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers). [1932(b)(6); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.230(c)] E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

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. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies

to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)] F.11.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies that the MCE must require all providers to report provider-preventable conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made. [42 CFR 438.6(f)(2)(ii); 42 CFR 434.6(a)(12)(ii)] F.14 Enhanced Payments for Primary Care Services F.14.1 [Applies to MCO, PIHP, PAHP] For calendar years (CY) 2013 and 2014 the contract requires the MCE to make enhanced payments for primary care services delivered by, or under the supervision of, a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.400(a); Increased Payment to PCPs Q&A] F.14.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to base enhanced primary care payments on the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the CY 2009 Medicare physician fee schedule conversion factor. If no applicable rate is established by Medicare, the MCE uses the rate specified in a fee schedule established by CMS. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405; Increased Payment to PCPs Q&A] F.14.3 [Applies to MCO, PIHP, PAHP] The contract stipulates that the MCE make enhanced primary care payments for all Medicaid- covered Evaluation and Management (E&M) billing codes 99201 through 99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, or their successor codes. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405(c); Increased Payment to PCPs Q&A] F.14.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide documentation to the state, sufficient to enable the state and CMS to ensure that primary care enhanced payments were made to network providers. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(B); Increased Payment to PCPs Q&A] F.17 EHR Incentive Payments F.17.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse electronic health records (EHR) incentive payments to eligible professionals, the contract establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate, in accordance with 42 CFR 438.6 c)(5)(iii). [1903(t); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.304; 42 CFR 495.310(c); 42 CFR 447.253(e); 42 CFR 495.370(a); SMD# 09-006, ATTACHMENT A] F.17.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates any of its responsibilities for administering EHR incentive payments to the MCE, the contract should describe the delegated activities. [42 CFR 438.6(c)(4)(ii)(A); Page 44514, Medicare and Medicaid Programs: Electronic Health Care Incentive Program: Final Rule, July 28, 2010]

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. J. General Terms and Conditions J.1 Inspection J.1.1 [Applies to MCO, PIHP, PAHP] The risk contract requires that the State agency and Department of Health and Human Services are allowed to inspect and audit any financial records of the MCE or its subcontractors. [42 CFR 438.6(g)] J.2 Compliance with State and Federal Laws J.2.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with all applicable Federal and State laws and regulations including: (1) Title VI of the Civil Rights Act of 1964 (2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities) (3) The Age Discrimination Act of 1975 (4) The Rehabilitation Act of 1973 - The Americans with Disabilities Act. [42 CFR 438.6(f)(1); 42 CFR 438.100(d)] J.2.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with applicable Federal and State laws regarding privacy and confidentiality. [42 CFR 438.6(f)(1); 42 CFR 438.100(d); 42 CFR 438.100(d)] J.4 Subcontracts J.4.4 [Applies to MCO, PIHP, PAHP] The MCE contract requires subcontracts entered into by the MCE to comply with any 42 CFR 438 requirements that pertain to the service or activity performed by the subcontractor. [42 CFR 438.6(l)] J.9 Insolvency J.9.3 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state or MCE does not pay the provider that furnishes the service under a contractual, referral, or other arrangement. [42 CFR 438.106(b)(2); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)] J.9.4 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCE provided the services directly. [42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)]

[ii] 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. C. Beneficiary Notification C.1 Timing for the Provision of Enrollee Information C.1.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to notify all enrollees of their right to request and obtain the information described in the "Enrollee Information" section of this review tool at least once a year. [42 CFR 438.10(f)(2)] C.1.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide each of its enrollees all of the information described in the "Enrollee Information" section of this review tool within a reasonable time after the MCE receives notice of the recipient's enrollment from the State or its contracted representative. [42 CFR 438.10(f)(3)] C.1.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to give each enrollee written notice of any significant change in the information described in the "Enrollee Information" section of this review tool at least 30 days before the intended effective date of the change. [42 CFR 438.10(f)(4)] C.2 Enrollee Information C.2.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs and PAHPs, this includes, at a minimum, information on primary care physicians, specialists, and hospitals. [42 CFR 438.10(f)(6)(i)] C.2.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on any restrictions on the enrollee's freedom of choice among network providers. [42 CFR 438.10(f)(6)(ii)] C.2.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be treated with respect and with due

consideration for their dignity and privacy. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(ii)] C.2.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iii)] C.2.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to participate in decisions regarding their health care, including the right to refuse treatment. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iv)] C.2.6 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be free from any form of restraint or seclusion. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(v)] C.2.7 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to request and receive a copy of their medical records and request that they be amended or corrected. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(vi)] C.2.8 [Applies to MCO, PIHP, PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to obtain available and accessible health care services covered under the MCE contract. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(3)] C.2.9 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. [42 CFR 438.10(f)(6)(v)] C.2.11 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on procedures for obtaining benefits, including authorization requirements. [42 CFR 438.10(f)(6)(vi)] C.2.12 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. [42 CFR 438.10(f)(6)(vii)] C.2.13 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the extent to which, and how, after-hours and emergency coverage are provided. This information must include at least the information described below. [42 CFR 438.10(f)(6)(viii)] C.2.14 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. [42 CFR 438.10(f)(6)(x)] C.2.15 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on cost sharing, if any. [42 CFR 438.10(f)(6)(xi)] C.2.16 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on how and where to access any benefits that are available under the State Plan but are not covered under the contract, including cost sharing and how transportation is provided. [42 CFR 438.10(f)(6)(xii)] C.2.17 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide adult enrollees with written information on advance directives polices, and include: (1) a description of applicable State law, (2) the MCE's advance directives policies, including a description of any limitations the MCE places on the implementation of advance directives as a matter of conscience, and (3) instructions that complaints concerning noncompliance with advance directives requirements may be filed with the state Survey & Certification agency. [42 CFR 438.6(i)(3); 42 CFR 438.6(i)(4); 42 CFR 438.10(g)(2); 42 CFR 438.10(h)(2)] C.2.19 [Applies to MCO, PIHP] If the state delegates this function, the contract requires the MCE to provide state-developed or state-approved information to enrollees on grievance, appeal and state fair hearing procedures and timeframes. This description must include at least the following: (1) Enrollees' right to a state fair hearing, (2) The method for obtaining a hearing, (3) The rules that govern representation at the hearing, (4) Enrollees' right to file grievances and appeals, (5) The requirements and timeframes for filing a grievance or appeal, (6) The availability of assistance for filing a grievance, appeal, or state fair hearing, (7) The toll free number the enrollee can use to file a grievance or appeal by phone, (8) The fact that benefits will continue, when requested by the enrollee, if the enrollee files a timely appeal or state fair hearing request, (9) The fact that the enrollee may be required to pay the cost of the continued services furnished while the appeal is pending if the final decision is adverse to the enrollee, (10) Any appeal rights the state makes available to providers to challenge the failure of the organization to cover a service. [42 CFR 438.10(g)(1)] C.2.20 [Applies to MCO, PIHP] If the state delegates this function, the contract requires the MCE to provide additional information that is available upon request, including information on the structure and operation of the MCE and the MCE's use of physician incentive plans. [42 CFR 438.10(g)(3)] C.2.21 [Applies to PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the right to a state fair hearing, the method for obtaining a hearing, and rules governing representation at the hearing. [42 CFR 438.10(h)(1)] C.2.22 [Applies to PAHP] If the state delegates this function, the contract requires the MCE to provide information, upon request, to enrollees on the MCE's use of physician incentive plans. [42 CFR 438.10(h)(3)] C.3 Disenrollment Information C.3.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to notify all enrollees of their disenrollment rights annually, at a minimum. [42 CFR 438.10(f)(1)] C.3.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to send notice no less than 60 days before the start of each enrollment period if the state restricts disenrollment during periods lasting 90 days or longer. [42 CFR 438.10(f)(1)] C.5 Provider Terminations C.5.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to make a good faith effort to give written notice within 15 days when an enrollee's primary care provider (or a provider they saw on a regular basis) is terminated. [42 CFR 438.10(f)(5)] C.7 Timing for the Provision of Potential Enrollee Information C.7.01 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide the information described in the "Potential Enrollee Information" section of this review tool to potential enrollees at the time they first become eligible in a voluntary program or are first required to enroll in a mandatory program and within a timeframe that enables the potential enrollee to use the information in choosing among available plans. [42 CFR 438.10(e)(1)] C.8 Potential Enrollee Information C.8.1 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide general information to potential enrollees about: (1) Basic features of managed care, (2) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. (3) The MCE's responsibilities for coordination of enrollee care. [42 CFR 438.10(e)(2)(i)] C.8.2 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide specific information to potential enrollees regarding each MCE program operating in the potential enrollee's service area, including: (1) Benefits covered, (2) Cost sharing, if any, (3) Service area, (4) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes at a minimum information on primary care physicians, specialists and hospitals, and (5) Benefits that are available under the state plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided (6) Counseling and referral services that

are not covered under the contract because of moral or religious objections. [42 CFR 438.10(e)(2)(ii); 42 CFR 438.102(b)(1)(ii)(A); 1932(b)(3)(B)(ii)] C.10 Easily Understood C.10.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to provide all enrollment notices, informational materials, and instructional materials in an easily understood format and manner. [42 CFR 438.10(b)(1)] C.10.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's written materials to use easily understandable language and format. [42 CFR 438.10(d)(1)(i)] C.10.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's written materials to be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. [42 CFR 438.10(d)(1)(ii)] C.10.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to inform all enrollees and potential enrollees about information available in alternative formats and how to access those formats. [42 CFR 438.10(d)(1)(ii)] C.11 Mechanism C.11.01 [Applies to MCO, PIHP] The contract requires the MCE to have a mechanism in place to help enrollees and potential enrollees understand the requirements and benefits of the plan. [42 CFR 438.10(b)(2); 42 CFR 438.10(b)(3)] C.12 Language C.12.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to make its written information available in the prevalent non-English languages identified by the state in its particular service area. [42 CFR 438.10(c)(3)] C.13 Interpretation C.13.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires each MCE to make oral interpretation services available free of charge to each enrollee and potential enrollee. [42 CFR 438.10(c)(4)] C.13.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that oral interpretation is available for any language and how to access those services. [42 CFR 438.10(c)(5)] C.13.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that written information is available in prevalent languages and how to access those services. [42 CFR 438.10(c)(5)]

[iii] 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.1 Advance Directives D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100]

[iv] 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.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)]

[v] 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.6 Provider Section D.6.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures include a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the MCE. [42 CFR 438.114(b)]

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. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to 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. [1932(b)(2); 42 CFR 438.114(a)] F.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines emergency service as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished by a provider that is qualified to furnish such services under Medicaid. [1932(b)(2); 42 CFR 438.114(a)] F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d)(2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c)(1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d)(2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. [1932(b)(2); 42 CFR 438.114(c)(1)(i)] F.1.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(c)(1)(ii)(A)] F.1.8 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when a representative of the MCE instructs the enrollee to seek emergency services. [42 CFR 438.114(c)(1)(ii)(B)] F.1.9 [Applies to PCCM] The contract requires the PCCM to allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR

438.114(c)(2)(i)] F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)] F.1.11 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030] F.1.12 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 438.114(d)(2)] F.1.13 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge. [42 CFR 438.114(d)(3)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[vi] 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. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d)(2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c)(1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d)(2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preautho45 CFR 164.308rization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies

to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[vii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicare & Medicaid Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)] D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100]

[viii] 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. C. Beneficiary Notification C.2 Enrollee Information C.2.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be treated with respect and with due consideration for their dignity and privacy. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(ii)] C.2.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iii)] C.2.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to participate in decisions regarding their health care, including the right to refuse treatment. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iv)] C.2.6 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be free from any form of restraint or seclusion. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(v)] C.2.7 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to request and receive a copy of their medical records and request that they be amended or corrected. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(vi)] C.2.8 [Applies to MCO, PIHP, PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to obtain available and accessible health care services covered under the MCE contract. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(3)]
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.15 Enrollee Rights D.15.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)] D.15.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iii)] D.15.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iv)] D.15.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. [42 CFR 438.100(b)(2)(vi); 42 CFR 438.100(a)(1)] D.15.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing enrollees' right to request and receive a copy of his or her medical records, and to request that they be amended or corrected. [42 CFR 438.100(b)(2)(v); 42 CFR 438.100(a)(1)] D.15.6 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that each enrollee is free to exercise his or her rights without the MCE or its providers treating the enrollee adversely. [42 CFR 438.100(c)]
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. J. General Terms and Conditions J.2 Compliance with State and Federal Laws J.2.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with all applicable Federal and State laws and regulations including: (1) Title VI of the Civil Rights Act of 1964 (2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities) (3) The Age Discrimination Act of 1975 (4) The Rehabilitation Act of 1973 - The Americans with Disabilities Act. [42 CFR 438.6(f)(1); 42 CFR 438.100(d)] J.2.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with applicable Federal and State laws regarding privacy and confidentiality. [42 CFR 438.6(f)(1); 42 CFR 438.100(d); 42 CFR 438.100(d)] J.2.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees. [42 CFR 438.100(a)(2)]

[ix] 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. H. Grievance and Appeals H.2 -10 Appeals Process H.2 Actions That May Be Appealed H.2.1 [Applies to MCO, PIHP] The MCE contract must define "appeal" as the request for review of an action. [42 CFR 431.201; 42 CFR 438.400(b); 42 CFR 438.52(b)(2)(ii); 42 CFR 438.56(c); (added in this citation as it is referenced in B.2.01 of State Guide to

CMS) 42 CFR 438.56(f)(2)] H.2.2 [Applies to MCO, PIHP] The MCE contract must define "action." The definition must include all of the elements described below. [42 CFR 431.201; 42 CFR 438.400(b); 42 CFR 438.52(b)(2)(ii); 42 CFR 438.56(f)(2)] Definition of Action: • Denial or limited authorization of a requested service, including the type or level of service. • Reduction, suspension, or termination of a previously authorized service. • Denial, in whole or in part, of payment for a service. • Failure to provide services in a timely manner, as defined by the State. • Failure of the MCE to process grievances, appeals or expedited appeals within required timeframes, or • For a rural area resident with only one MCO, the denial of a Medicaid enrollee's request to obtain services outside the network: 1. From any other provider (in terms of training, experience, and specialization) not available within the network. 2. From a non-network provider who is the main source of a service to the recipient, as long as that provider is given the same opportunity to become a participating provider, as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days. 3. Because the only plan or provider available does not provide the service due to moral or religious objections. 4. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network. 5. The State determines that other circumstances warrant out-of-network treatment. H.11 Grievances H.11.1 [Applies to MCO, PIHP] The MCE contract defines a grievance as an expression of dissatisfaction about any matter other than an "action". [42 CFR 438.400(b)]

[x] 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. H. Grievance and Appeals H.10 Continuation of Benefits H.10.4 [Applies to MCO, PIHP] The contract requires the MCE to authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal was pending and if the MCE or State Fair Hearing Officer reverses a decision to deny, limit, or delay services. [42 CFR 438.424(a)] H.10.5 [Applies to MCO, PIHP] The contract requires the MCE to pay for disputed services received by the enrollee while the appeal was pending, unless State policy and regulations provide for the State to cover the cost of such services, when the MCE or State Fair Hearing Officer reverses a decision to deny authorization of the services. [42 CFR 438.424(b)]
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. K. State Obligations K.2 State Fair Hearing Process K.2.5 [Applies to MCO, PIHP] The contract requires the MCE to pay for disputed services received by the enrollee while the appeal was pending (unless State policy and regulations provide for the State to cover the cost of such services) when the MCE or State Fair Hearing Officer reverses a decision to deny authorization of the services. [42 CFR 438.424(b)]

[xi] 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. H. Grievance and Appeals H.10 Continuation of Benefits H.10.1 [Applies to MCO, PIHP] The contract requires that the MCE continue the enrollee's benefits while an appeal is in process if all of the following conditions are met: (1) The appeal is filed on or before the later of the following: (a) Within 10 days of the MCE mailing the notice of action, or (b) The intended effective date of the MCE's proposed action. (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) The services were ordered by an authorized provider. (4) The authorization period has not expired. (4) The enrollee requests extension of benefits. [42 CFR 438.420(a); 42 CFR 438.420(b)] H.10.2 [Applies to MCO, PIHP] The contract requires that if the MCE continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: (1) The enrollee withdraws the appeal, (2) The enrollee does not request a State Fair Hearing with continuation of benefits within 10 days from the date the MCE mails an adverse appeal decision, (3) A State Fair Hearing decision adverse to the enrollee is made, or (4) The service authorization expires or authorization limits are met. [42 CFR 438.420(c)] H.10.3 [Applies to MCO, PIHP] The contract provides that the MCE may recover the cost of the continued services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the MCE's action. [42 CFR 438.420(d); 42 CFR 431.230(b)]

[xii] 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 CHIP SERVICES, 2015. Print. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b) (4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]

[xiii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. B. Enrollment and Disenrollment B.4 Reenrollment B.4.1. [Applies to MCO, PIHP, PAHP, PCCM] If specified by the federal authority (SPA or waiver) approved by CMS, the contract provides for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. [42 CFR 438.56(g)]

[xiv] 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. J. General Terms and Conditions J.6 Sanctions J.6.8 [Applies to MCO, PCCM] The contract provides that if the MCE violates any other applicable requirements in 1903(m), 1932 or 1905(t) of the Act, the state may impose only the following sanctions: (1) Grant enrollees the right to disenroll without cause (2) Suspend all new enrollments to the MCE (3) Suspend payments for all new enrollments to the MCE. [43 CFR 438.700(d); 42 CFR 438.702(a)(3),(4)&(5); 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E)]

[xv] 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. B. Enrollment and Disenrollment B.5 Disenrollment B.5.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of a change in the enrollee's health status. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's utilization of medical services. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.4. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's diminished mental capacity. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.5. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCEs ability to furnish services to the enrollee or other enrollees). [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)]

[xvi] 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. E. Providers and Provider Network E.1 Network Adequacy E.1.3 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE maintain a network of appropriate providers that is supported by written agreements. [42 CFR 438.206(b)(1)] E.1.4 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. [42 CFR 438.206(b)(1)] E.1.5 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider how many Medicaid beneficiaries may enroll. [42 CFR 438.206(b)(1)(i)] E.1.6 [Applies to MCO, PIHP, PAHP] The contract requires that, when establishing and maintaining its network, the MCE consider the expected utilization of services, given the characteristics and health care needs of the specific Medicaid populations enrolled in the MCE. [42 CFR 438.206(b)(1)(ii)] E.1.7 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider the numbers and types (their training, experience and specialization) of providers required to provide the necessary Medicaid services. [42 CFR 438.206(b)(1)(iii)] E.1.8 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider the numbers of network providers who are not accepting new Medicaid patients. [42 CFR 438.206(b)(1)(iv)] E.1.9 [Applies to MCO, PIHP, PAHP] The contract requires that, when establishing and maintaining its network, the MCE consider the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. [42 CFR 438.206(b)(1)(v)] E. Providers and Provider Network E.5 Access E.5.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE and its providers meet the State standards for timely access to care and services, taking into account the urgency of need for services. [42 CFR 438.206(c)(1)(i)] E.5.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's network providers offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. [42 CFR 438.206(c)(1)(ii)] E.5.3 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to make services available 24 hours a day, 7 days a week, when medically necessary. [42 CFR 438.206(c)(1)(iii)] E.5.4 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to establish mechanisms to ensure that the network providers comply with the timely access requirements. [42 CFR 438.206(c)(1)(iv)] E.5.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to monitor providers regularly to determine compliance with the timely access requirements. [42 CFR 438.206(c)(1)(v)] E.5.6 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to take corrective action if it, or its providers, fail to comply with the timely access requirements. [42 CFR 438.206(c)(1)(vi)]

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. F. Coverage F.5 Women's Health Specialist F.5.01 [Applies to MCO, PIHP, PAHP] If a female enrollee's designated Primary Care Provideris not a women's health specialist, the contract requires the MCE to provide the enrollee with direct access to a women's health specialist within the network for covered routine and preventive women's health care services. [42 CFR 438.206(b)(2)] F.6 Second Opinions F.6.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide for a second opinion from a qualified Health Care Providerwithin the network, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee. [42 CFR 438.206(b)(3)] F.7 Out-of-Network Care F.7.1 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCE must adequately and timely cover the services out of network, for as long as the MCE is unable to provide them. [42 CFR 438.206(b)(4)] F.7.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to coordinate payment with out of network providers and ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network. [42 CFR 438.206(b)(5)]

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.7 Cultural Competence G.7.01 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)]

[xvii] 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.6 Provider Section D.6.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.214(c)] I. Program Integrity I.1 Exclusions I.1.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE not employ or contract with providers excluded from participation in Federal health care programs. [42 CFR 438.214(d)] K. State Obligations K.8 Credentialing and Re-credentialing Policy K.8.01 [Applies to MCO, PIHP, PAHP] The contract specifies that the state-established uniform provider credentialing and re credentialing policy must be followed by the MCE. [42 CFR 438.214(b)(1)]

[xviii] 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.11 Timely Payment D.11.1 [Applies to MCO] The contract requires that the MCE will meet the requirements of FFS timely payment, including the paying of 90% of all clean claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99 percent of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt. [42 CFR 447.45 (d)(3)] D.11.2 [Applies to MCO] The contract requires that the MCE ensure that the date of receipt is the date the MCE receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment. [42 CFR 447.45 (d)(3)]

[xix] 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 CHIP SERVICES, 2015. Print. D. MCE Policies, Procedures, and Systems D.6 Provider Section D.6.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures include a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the MCE. [42 CFR 438.114(b)]

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 CHIP SERVICES, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to 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. [1932(b) (2); 42 CFR 438.114(a)] F.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines emergency service as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished by a provider that is qualified to furnish such services under Medicaid. [1932(b) (2); 42 CFR 438.114(a)] F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d) (2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c) (1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d) (2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. [1932(b) (2); 42 CFR 438.114(c) (1) (i)] F.1.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(c)(1)(ii)(A)] F.1.8 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when a representative of the MCE instructs the enrollee to seek emergency services. [42 CFR 438.114(c)(1)(ii)(B)] F.1.9 [Applies to PCCM] The contract requires the PCCM to allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR 438.114(c)(2)(i)] F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)] F.1.11 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030] F.1.12 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 438.114(d)(2)] F.1.13 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge. [42 CFR 438.114(d)(3)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-

stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[xx] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030]

[xxi] 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.8 Special Health Care Needs G.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. [42 CFR 438.208(c)(2)]

[xxii] 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)]

[xxiii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. G. Quality and Utilization Management Medical Record Content G.6.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that medical record content must include at a minimum for hospitals and mental hospitals: (1) Identification of the beneficiary. (2) Physician name. (3) Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 456.172 (mental hospitals) or 456.70 (hospitals). (4) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals). (5) Reasons and plan for continued stay if applicable. (6) Other supporting material the committee believes appropriate to include. For non-mental hospitals only: (7) Date of operating room reservation. (8) Justification of emergency admission if applicable. [42 CFR 456.111; 42 CFR 456.211]

[xxiv] 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. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)]

[xxv] 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 & Chip Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO,

PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[xxvi] 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. K. State Obligations K.5 No Supplemental Payments K.5.01 [Applies to MCO, PIHP, PAHP] The contract provides that the State agency must ensure that no payment is made to a provider other than the MCE for services available under the contract between the State and the MCE, except when these payments are specifically provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, for graduate medical education. [42 CFR 438.60]

[xxvii] 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. E. Providers and Provider Network E.1 Network Adequacy E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

[xxx] 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. F. Coverage F.12 Cost Sharing F.12.1 [Applies to MCO, PIHP, PAHP] The contract requires that any cost sharing imposed on Medicaid enrollees is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.60. [1916(a)(2)(D); 1916(b)(2)(D); 42 CFR 438.108; 42 CFR 447.50-60; SMD letter 6/16/06]

[xxxi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. F. Coverage F.12 Cost Sharing F.12.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services. The contract requires the MCE to exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. [42 CFR 447.52(h); 42 CFR 42 CFR 447.56 (a)(1)(x); ARRA 5006(a); SMD 10-001]

[xxxiii] 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. I. Program Integrity I.2 Requirements, procedures, and reporting I.2.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having a director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09] I.2.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having a person with ownership of more than 5% of the MCE's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09] I.2.6 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having an employment, consulting, or other agreement with an

individual or entity for the provision of MCE contract items or services who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09]
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. K. State Obligations K.3 Program Integrity K.3.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the State learns that an MCE has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the State,: (1) Must notify the Secretary of the noncompliance. (2) May continue an existing agreement with the MCE unless the Secretary directs otherwise. (3) May not renew or extend the existing agreement with the MCE unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement. [42 CFR 438.610(c)]

[xxxiv] 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. I. Program Integrity I.1 Exclusions I.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract establishes that FFP is not available for any amounts paid to an MCE that could be excluded from participation in Medicare or Medicaid for any of the following reasons: (1) The MCE is controlled by a sanctioned individual (2) The MCE has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act (3) The MCE employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (a) Any individual or entity excluded from participation in Federal health care programs. (b) Any entity that would provide those services through an excluded individual or entity. [1903(i)(2); 42 CFR 431.55(h); 42 CFR 438.808; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMD letter 6/12/08; SMD letter 1/16/09]

[xxxv] 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. F. Coverage F.14 Enhanced Payments for Primary Care Services F.14.1 [Applies to MCO, PIHP, PAHP] For calendar years (CY) 2013 and 2014 the contract requires the MCE to make enhanced payments for primary care services delivered by, or under the supervision of, a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.400(a); Increased Payment to PCPs Q&A] F.14.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to base enhanced primary care payments on the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the CY 2009 Medicare physician fee schedule conversion factor. If no applicable rate is established by Medicare, the MCE uses the rate specified in a fee schedule established by CMS. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405; Increased Payment to PCPs Q&A] F.14.3 [Applies to MCO, PIHP, PAHP] The contract stipulates that the MCE make enhanced primary care payments for all Medicaid- covered Evaluation and Management (E&M) billing codes 99201 through 99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, or their successor codes. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405(c); Increased Payment to PCPs Q&A] F.14.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide documentation to the state, sufficient to enable the state and CMS to ensure that primary care enhanced payments were made to network providers. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(B); Increased Payment to PCPs Q&A] F.17 EHR Incentive Payments F.17.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse electronic health records (EHR) incentive payments to eligible professionals, the contract establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate , in accordance with 42 CFR 438.6 c)(5)(iii). [1903(t); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.304; 42 CFR 495.310(c); 42 CFR 447.253(e); 42 CFR 495.370(a); SMD# 09-006, ATTACHMENT A] F.17.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates any of its responsibilities for administering EHR incentive payments to the MCE, the contract should describe the delegated activities. [42 CFR 438.6(c)(4)(ii)(A); Page 44514, Medicare and Medicaid Programs: Electronic Health Care Incentive Program: Final Rule, July 28, 2010]

[xxxvii] 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. J. General Terms and Conditions J.6 Sanctions J.6.11 [Applies to MCO] The MCE contract specifies the circumstances under which the state will impose optional temporary management. Temporary management may only be imposed when: There is continued egregious behavior by the MCE, there is substantial risk to enrollees' health, or the sanction is necessary to ensure the health of the MCE's enrollees. [42 CFR 438.706(a); 1932(e)(2)(B)(i)] J.6.12 [Applies to MCO] The MCE contract specifies that the state must impose mandatory temporary management and grant enrollees the right to terminate MCE enrollment without cause when an MCE repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438. The state may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the MCE can ensure the sanctioned behavior will not reoccur. [42 CFR 438.706(b); 1932(e)(2)(B)(ii)] K. State Obligations K.4 Contract Sanctions and Terminations K.4.2 [Applies to MCO] The contract specifies that if the state imposes temporary management because an MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438 , the state must notify affected enrollees of their right to terminate enrollment without cause. [42 CFR 438.706(b)]

[xxxviii] 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. J. General Terms and Conditions J.6 Sanctions J.6.1 [Applies

to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the MCE distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the state may impose a civil monetary penalty of up to $25,000 for each distribution. [42 CFR 438.700(c); 42 CFR 438.704(b)(1)(iv); 1932(e)(1)(A); 1932(e)(2)(A)(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. K. State Obligations K.4 Contract Sanctions and Terminations K.4.1 [Applies to MCO, PCCM] The contract specifies that if the state imposes a civil monetary penalty on the MCE for charging premiums or charges in excess of the amounts permitted under Medicaid, the state deducts the amount of the overcharge from the penalty and returns it to the affected enrollee. [42 CFR 438.704(c)]

[xxxix] 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 & Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.1 [Applies to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right

to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the MCE distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the state may impose a civil monetary penalty of up to $25,000 for each distribution. [42 CFR 438.700(c); 42 CFR 438.704(b)(1)(iv); 1932(e)(1)(A); 1932(e)(2)(A)(i)]

[xli] 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 CHIP SERVICES, 2015. Print. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b) (4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]

[xlii] 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. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b)(4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]