AGREEMENT
BETWEEN
THE RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
AND
BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

THIS AGREEMENT("Agreement") is made and entered into by the Rhode Island Executive Office of Health and Human Services ("EOHHS"), an administrative agency within the executive department of the State of Rhode Island having its principal office at the Virks Building, 3 West Road, Cranston, Rhode Island 02920, and Blue Cross & Blue Shield of Rhode Island("Medicare Advantage Health Plan" or "MA Health Plan"), a corporation organized under the laws of the state of Rhode Island with a principal business address of 500 Exchange Street, Providence, Rhode Island, 02903.

Article I. BACKGROUND

The MA Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to provide an MAPD Plan ("MA Agreement") under Title XVIII and XIX of the Social Security Act, including Medicare Advantage Special Needs Plan (SNPs) that arrange for the provision of Medicare services for individuals who are dually-eligible for both Medicare and Medicaid benefits.

Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the MA Health Plan to enter into an agreement with Rhode Island documenting the MA Health Plan's obligations to provide or arrange for Medicaid benefits to be provided to dually eligible individuals. As a result, the MA Health Plan and EOHHS wish to enter into this agreement which shall outline each party's obligations to provide or arrange for benefits for Dual Eligible Members.

In consideration of the premises and the mutual promises and undertakings contained herein, the parties agree to the following terms and conditions.

Article II. DEFINITIONS

Affiliate means with respect to any person or entity, any other person or entity which directly or indirectly controls, is controlled by or is under common control with such person or entity.

Care Coordination is defined as the organized delivery of member care activities between two (2) or more participants (including the Dual-Eligible Member) involved in a Member's care to facilitate the appropriate delivery of Medicare and/or Medicaid 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.

Cost Sharing Obligations mean those financial payment obligations incurred by EOHHS in satisfaction of the Deductibles, Coinsurance, and Co-payments for the Medicare Part A and Part B services with respect to specified Dual Eligible Members. For purposes of this Agreement, Cost Sharing Obligations do not include: (1) Medicare premiums that EOHHS is required to pay under the State Plan on behalf of Dual Eligible Members, or (2) any other services that are covered solely by the Rhode Island Medicaid Program

("Medicaid")

Category	Medicare Part A Premiums	Medicare Part B Premiums	Medicare Cost Sharing (Except Part D)		Other Medicaid Benefits
			Part A	Part B	
QMB Only	x	x	x	x	
QMB Plus	x	x	x	x	x
FBDE	x	x	x	x	x
SLMB Plus		x	x	x	x
SLMB		x			
QI		x			
QDWI	x				

Days mean calendar days unless otherwise specified.

Dual Eligible means a Medicare managed care recipient who is also eligible for Medicaid, and for whom EOHHS has a responsibility for payment of Cost Sharing Obligations under the State Plan. MA Health Plan may enroll only those categories of Dual Eligible individuals identified in **Appendix A**.

Dual Eligible Member means a Dual Eligible who is eligible to participate in, and voluntarily enrolled in, the MA Health Plan's MAPD Plan.

Dual Special Needs Plan or D-SNP means a specialized MAPD Plan for special needs individuals who are entitled to medical assistance under a state plan under Title XIX of the Social Security Act that satisfies the requirements for such plans at 42 C.F.R. § 422.2.

Full Benefit Dual Eligible Members (FBDE aka Medicaid only) means an individual who does not meet the income or resource criteria for QMB or SLMB but is eligible for Medicaid either categorically or through optional coverage groups such as medically needy, or special income levels for institutionalized, or home and community-based waivers. FBDEs are eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments (except for Medicare Part D) as well as Full Medicaid benefits.

MA Agreement means the Medicare Advantage Agreement between the MA Health Plan and CMS to provide Medicare Part C and other health plan services to the MA Health Plan's members.

MAPD Plan means the CMS approved Medicare Advantage plan sponsored, issued, or administered by the MA Health Plan as defined at 42 C.F.R. § 423.4 and includes, but is not limited to, Dual-Eligible Special Needs Plans or D-SNPs as defined in the Medicare Advantage Regulations.

Qualified Disabled and Working Individuals (QDWI) means an individual lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise

eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

Qualified Medicare Beneficiary (QMB) means an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments (except for Medicare Part D) ("QMB Medicaid Benefits").

- **QMB Only** – QMBs who do not qualify for any additional QMB Medicaid Benefits.
- **QMB Plus** – QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medicaid Benefits, plus all benefits under the State Plan for fully eligible Medicaid recipients.

Qualifying Individuals (QI) means an individual is entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Specified Low-Income Medicare Beneficiary (SLMB): An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less than 120% FPL, and resources do not exceed twice the SSI limit and are not otherwise eligible for Medicaid. A SLMB is eligible for Medicaid payment of Medicare Part B premium only.

SLMB Plus – SLMBs that are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limits for SSI eligibility, and are also eligible for full Medicaid coverage. Such individuals are entitled to Medicaid payment of the Medicare Part B premium, as well as full State Medicaid benefits.

State Plan means the State of Rhode Island's plan for the Medical Assistance Program as submitted by EOHHS and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

Subcontract means an agreement between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services and/or administrative services for the MA Health Plan's members.

Subcontractor means a third party with which the MA Health Plan has a Subcontract.

Article III. MA HEALTH PLAN'S OBLIGATIONS

Section 3.01 *Service Area.*

(a) The MA Health Plan will offer a D-SNP to the categories of Dual Eligibles identified on **Appendix A** who: (1) reside in the State, county or zip code where the MA Health Plan offers the D-SNP, and (2) are otherwise eligible to enroll in the D-SNP. The MA Health Plan will also identify the service area of the D-SNP according to either counties or zip codes on **Appendix A**.

Section 3.02 *Enrollment*

(a) Prior to enrollment, the MA Health Plan will verify a potential Dual Eligible Member's Medicare eligibility. Unless a Dual Eligible is otherwise excluded under federal Medicare Advantage plan rules or **Appendix A**, the MA Health Plan will accept all Dual Eligible individuals who select the MA Health Plan's D-SNP Plan without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of suchdiscrimination. Categories of Dual Eligible individuals eligible by this Agreement are:

CATEGORY OF DUAL ELIGIBLE	ELIGIBLE FOR SPECIAL NEEDS PLAN (Y/N)
QMB ONLY	Y
QMB PLUS	Y
SLMB	Y
SLMB PLUS	Y
FBDE	Y
QI	Y
QDWI	Y

(b) Prior to enrollment, the MA Health Plan will verify a potential Dual Eligible Member's Medicaid eligibility. The MA Health Plan may also conduct ongoing eligibility verification of Dual Eligible Members. As outlined in Article IV, EOHHS will provide MA Health Plan with real-time access to the State's eligibility system or otherwise agree to a data exchange of information that allows the MA Health Plan to verify a potential Dual Eligible Member's current Medicaid status.

(c) The MA Health Plan may choose to use a Subcontractor to conduct eligibility verification outlined in this Section so long as the Subcontractor has met EOHHS' requirements for access to the State eligibility database.

(d) The MA Health Plan agrees to provide EOHHS on an annual basis its approved Model of Care (MOC) to ensure alignment with EOHHS expectations and care coordination of Medicaid benefits.

(e) The MA Health Plan agrees to provide EOHHS with its marketing strategy and approach for new members and any materials that provide information specific to Medicaid services for EOHHS review, which shall include, at a minimum, the Evidence of Coverage (member handbook), Annual Notice of Change and Summary of Benefits.

Section 3.03 *Benefits.*

(a) The MA Health Plan will provide the D-SNP pursuant to this agreement to Dual Eligible Members who are qualified and are enrolled to receive such services under the eligibility requirements of the D-SNP.

(b) The MA Health Plan is not responsible for providing or reimbursing any Medicaid benefits for Full

Dual Eligibles under this Agreement or the Medicaid Managed Care Plan operated by another entity owned by the same parent organization as MA Health Plan. MA Health Plan shall maintain current knowledge and familiarity of State Plan benefits through ongoing reviews of Rhode Island laws, rules, policies, and further guidance as posted on the EOHHS website. The MA Health Plan shall timely coordinate State Plan benefits for its enrolled Dual Eligible Members as described in **Appendix B** of this Agreement. Rhode Island Medicaid covered services are described in Title XIX of the Social Security Act, 42 CFR §§440 and 441; the EOHHS website; and other relevant materials.

(c) The MA Health Plan will identify for Dual Eligible Members in the D-SNP's Summary of Benefits those benefits the member may be eligible for under the State Plan that are not covered services under the Member's D-SNP n. The D-SNP is responsible to coordinate access to such benefits. EOHHS is responsible for providing the D-SNP with the State Plan benefits outlined in **Appendix B**. The Medicaid covered benefits outlined in **Appendix B** include the medical, behavioral, and long-term services and supports (LTSS) benefit package for full dual eligible enrollees based on Medicaid eligibility determination. LTSS services are covered only when a Medicaid enrollee has been determined eligible for LTSS. All Medicaid covered services outlined in **Appendix B** are provided through the Medicaid FFS program.

Service 3.04 *Coordination*

(a) The MA Health Plan is responsible for care coordination of all benefits covered by both Medicare and Medicaid benefits delivered via Rhode Island Medicaid Program's fee-for-service plan for Dual Eligible Members. EOHHS will provide contact and resource information, to the extent available, that allows the MA Health Plan to access information regarding the State Plan, including Medicaid benefits, providers, case managers and waiver programs. Consistent with the MA Health Plan's Model of Care, coordination of care for Dual Eligible Members by the MA Health Plan will include the following:

i. Identifying for Dual Eligible Members in the MA Health Plan'sSummary of Benefit those benefits the Dual Eligible Member may be eligible for under the State Plan that are not covered services under the D-SNP to the extent that EOHHS has provided State Plan benefit information outlined in Article IV and **Appendix B** of this agreement.

ii. Providing Dual Eligible Members with information (including contact information) and warm transfer to access Medicaid benefits upon the Dual Eligible Member's request or as identified by the case coordinator or other MA Health Plan staff.

iii. Participation and completion of Rhode Island Medicaid HCBS training by member facing staff, especially care management and member services staff.

iv. Coordinating benefits directly with the EOHHS, its program representatives, contractors, and providers, including implementation of a process and procedure for the notification and sharing of LTSS care plans, as appropriate, to coordinate care and ensure continuity of care.

v. Coordinating access to Medicaid covered services upon the Dual Eligible Member's request or as identified by the MA Health's Plan's care coordinator. Such coordination may include but is not limited to identification of and referrals to needed services, assistance with Medicaid appeals and grievances, assistance in care planning, and assistance in obtaining appointments for needed services.

vi. Identifying Medicaid participating providers for the Dual Eligible Members to the extent EOHHS has provided such information as outlined in Article IV of this Agreement.

vii. Making information available to MA Health Plan's network providers regarding Medicaid so that they may assist Dual Eligible Members to receive needed services not covered by Medicare.

viii. Providing information to MA Health Plan's network providers about coordination of Medicaid and Medicare benefits for Dual Eligible Members.

(b) EOHHS will provide contact and resource information, to the extent available, that allows the MA Health Plan to access information regarding the State Plan, including the State Plan's Medicaid benefits, Medicaid providers, State Plan's case managers, and the State Plan's waiver program.

(c) For high-risk members, defined as all Full Dual Eligible Members (QMB Plus, SLMB Plus, and FBDE) and/or any members with Medicaid coverage, the MA Health Plan shall provide timely notification to EOHHS of all admissions to a hospital and skilled nursing facility (SNF). "Timely notification" is defined as daily, automated file exchange. Every day, seven days a week, the D-SNP will upload a file to a Secure File Transfer Protocol ("SFTP") site. The file shall be organized and populated in accordance with the template mutually agreed upon by EOHHS and MA Health Plan and shall identify the MA Health Plan's Full Dual Eligible members who experienced a hospital or SNF admission that the MA Health Plan was made aware of within the previous 48 hours.

Section 3.05 *Enrollee Liability for Payment.*

(a) The MA Health Plan and its contracted providers are prohibited from imposing cost- sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the Rhode Island State Plan for Medical Assistance, per section 1852(a)(7) of the Act and 42 CFR§422.504(g)(1)(iii).

(b) Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to the MA Health Plan for Medicare Part A or Part B cost sharing amounts. The MA Health Plan's provider agreements shall specify that a contracted Medicare provider agrees to accept the MA Health Plan's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill EOHHS as applicable for any additional Medicare payments that may be reimbursed by Medicaid. Dual Eligible Members shall be responsible for any applicable Medicaid copayments.

Section 3.06 *Third Party Liability & Coordination of Benefits.*

(a) EOHHS is responsible for adjudicating the Cost Share Obligations under the State Plan. The MA Health Plan will adjudicate and pay claims in accordance with Medicare rules and regulations and provide evidence of payment information to providers, which identifies coordination amounts for their claim submission to the State Plan. Pursuant to the State Plan, EOHHS will remain financially responsible for Cost-Sharing Obligations and Medicaid Benefits for Dual Eligible Members. EOHHS may have financial responsibility for Medicare Part A and/or Part B premiums for Dual

Eligible Member. EOHHS is not responsible for payment of Medicare Advantage premiums for mandatory or optional Supplement Benefits, unless specifically prescribed in the State Plan.

Section 3.07 *Required Program Reports*

(a) Clinical Data

i. The MA Health Plan must report clinical indicator data to EOHHS for all Dual Eligible Members in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA). The MA Health Plan must comply with, and report to EOHHS, the HEDIS SNP Measures as required and approved by NCQA and CMS and report to EOHHS on the same time schedule required by CMS.

ii. The HEDIS measures must be collected according to HEDIS specifications or other specifications as specified by EOHHS, and reported to EOHHS with the annual reports, unless CMS requires submission of those materials on a different time schedule.

(b) Consumer Assessment of Healthcare Providers and Services (CAHPS) Data

i. The MA Health Plan must submit the Consumer Assessment of Healthcare Providers and Services (CAHPS) data to EOHHS annually, on the anniversary of the start date of the Agreement.

Article IV. DEPARTMENT OBLIGATIONS

Section 4.01 *Eligibility Verification.*

(a) EOHHS agrees to provide the MA Health Plan or its Subcontractors with real-time access to information that permits the MA Health Plan to verify eligibility of potential and/or existing Dual Eligible Members. EOHHS will provide the MA Health Plan with information within a reasonable time frame to allow the MA Health Plan to identify the specific categories of eligibility of Dual Eligibles. Information obtained by the MA Health Plan from EOHHS's eligibility verification system shall not be used by the MA Health Plan for marketing purposes. In collaboration with EOHHS, the MA Health Plan shall implement a process to inform enrollees of annual Medicaid re-certification period through education and application assistance.

Section 4.02 *Sharing of Information*

(a) The MA Health Plan shall obtain certain pieces of information from EOHHS to comply with CMS requirements for D-SNPs. In particular:

i. EOHHS will provide the MA Health Plan with a list of services and products for which Dual Eligible and Other Dual Eligible individuals are eligible for under the State Plan on an annual

basis. EOHHS will provide the aforementioned information on an ad-hoc basis if significant changes occur during the middle of the year. EOHHS will provide the aforementioned information by May of the preceding year if CMS requires the MA Health Plan to provide such information in the MA Health Plan's Summary of Benefits and/or Evidence of Coverage.

ii. EOHHS will provide the MA Health Plan with an electronic data file containing Medicaid participating providers in a mutually agreed upon format. Once EOHHS provides an electronic data file list of participating Medicaid providers, the MA Health Plan will list in the provider directory those health care providers that are participating in both the State Plan and the D-SNP's provider network.

Article V. TERM, TERMINATION

Section 5.01 Term.

(a) The initial term of this Agreement will begin on **January 1, 2023** (the "Effective Date") and end on **December 31, 2023**. Upon expiration of the initial term, the term of this Agreement shall automatically renew for successive twelve (12) month renewal terms on each applicable January 1st, unless either party provides the other with written notice of nonrenewal no later than June 1st of the previous year.

Section 5.02 Termination.

(a) This Agreement may be terminated by mutual agreement of the parties. Such agreement must be in writing. The effective date of termination is dependent on any pertinent CMS requirements, including CMS requirements related to notification of Dual Eligible Members.

(b) In the event CMS notifies the MA Health Plan that the MA Health Plan will not be permitted to continue offering a D-SNP (or plan benefit package) that is listed in **Appendix A**, the MA Health Plan may terminate this Agreement by notifying EOHHS. The termination will be effective on the date specified in the MA Health Plan's notice to EOHHS.

(c) In the event of termination pursuant to this Section, EOHHS will continue to provide the MA Health Plan access to the EOHHS eligibility database through the end of the MAPD plan year for purposes of confirming Medicaid eligibility. In addition, the parties shall discuss whether to enter into an alternative arrangement for the exchange of Medicaid eligibility information.

Article VI. DISPUTE RESOLUTION

Section 6.01 General Agreement of the Parties.

(a) The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this Agreement. The parties express their mutual commitment to using all reasonable and informal meansof resolving disputes prior to invoking a remedy provided elsewhere in this Section.

Section 6.02 *Duty to Negotiate in Good Faith.*

(a) Any dispute that in the judgment of any party to this Agreement may materially or substantially affect the performance of this Agreement will be reduced to writing and delivered to the other party. The parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by agreement between the parties shall be reduced to writing and delivered to all parties within ten (10) business days.

Section 6.03 *Arbitration.*

(a) If the parties are unable to resolve any dispute arising under this Agreement within sixty (60) Days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the dispute, it shall thereafter be submitted to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the dispute must initiate the arbitration within one (1) year after the date on which notice of the dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

(b) Any arbitration proceeding under this Agreement shall be conducted in Rhode Island. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or specialdamages, except in connection with a statutory claim that explicitly provides for such relief.

(c) The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the dispute related to this Agreement. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

(d) The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreementaffects interstate commerce the Federal Arbitration Act applies.

(e) In the event any court determines that this arbitration. procedure is not binding or otherwise allows litigation involving a dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

This Section shall govern any dispute between the parties arising before or after execution of this Agreement and shall survive any termination of the Agreement.

Article VII. MISCELLANEOUS PROVISIONS

Section 7.01 *Entire Agreement.*

(a) This Agreement contains the entire understanding between the parties hereto with respect to the subject matter of this Agreement and supersedes any prior understandings, agreements or representations, written or oral, relating to the subject matter of this Agreement.

Section 7.02 *Signatures & Counterparts.*

(a) This Agreement will be effective only when signed by both parties. This Agreement may be executed in separate counterparts, each of which will be an original and all of which taken together will constitute one and the same agreement, and a party hereto may execute this Agreement by signing any such counterpart. This Agreement may be signed by means of electronic signatures.

Section 7.03 *Non-Debarment.*

(a) The MA Health Plan represents that neither it nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program.

Section 7.04 *Severability.*

(a) Whenever possible, each provision of this Agreement will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this Agreement is held to be invalid, illegal or unenforceable under any applicable law or rule, the validity, legality and enforceability of the other provisions of this Agreement will not be affected or impaired thereby.

Section 7.05 *Successors & Assigns.*

(a) This Agreement will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by Section 7.06, successors and assigns.

Section 7.06 *Assignment.*

(a) This Agreement and the rights and obligations of the parties under this Agreement will be assignable, in whole or in part, by the MA Health Plan with

i. prior notice if to an MA Health Plan Affiliate or

ii. with the prior written consent of EOHHS's point of contact identified in Section 7.08.

Section 7.07 *Modification, Amendment, or Waiver.*

(a) No provision of this Agreement may be modified, amended, or waived except by a written signed by parties to this Agreement. No course of dealing between the parties will modify, amend, or waive any provision of this Agreement or any rights or obligations of any party under or by reason of this Agreement.

Section 7.08 *Notices.*

(a) All notices, consents, requests, instructions, approvals or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, United States mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

Rhode Island Executive Office of Health& Human Services

Kristin Pono Sousa
Medicaid Program Director

3 West Road,
Virks Building
\Cranston, RI 02918

BlueCross BlueShield of Rhode Island

Christina Pitney
Sr. Vice President,
Government Programs

500 Exchange Street,
Providence, RI 02903

(b) A party may change the contact information set forth above by giving written notice to the other party.

Section 7.09 *Headings.*

(a) The headings and any table of contents contained in this Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

Section 7.10 *Compliance with Federal and State Law.*

(a) The parties agree to comply with all relevant federal and state laws, including but not limited to the following: Bipartisan Budget Act of 2018 and its implementing regulations issued by CMS; the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS; 42 CFR Part 422; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC §§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of theOmnibus Budget Reconciliation Act of 1981, as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC § 6101 et seq.).

Section 7.11 Governing Law & Venue.

(a) This Agreement is governed by the laws of the State of Rhode Island and interpreted in accordance with Rhode Island law, except to the extent preempted by federal law. Provided the parties first comply with the procedures set forth in Article VI, "Dispute Resolution," proper venue for claims arising from this Agreement will be in a court of competent jurisdiction in Rhode Island.

Section 7.12 No Third-party Beneficiaries.

(a) Nothing in this Agreement, express or implied, is intended to confer upon any other person any rights, remedies, obligations or liabilities of any nature whatsoever.

Section 7.13 Publicity.

(a) Except as otherwise required by this Agreement of by law, no party will issue or cause to be issued any press release or make or cause to be made any other public statement as to this Agreement or the relationship of the parties, without providing notice to the other party of the contents and manner of presentation and publication thereof and receiving that other party's written consent. Either party shall have the ability to specifically request that prior consent shall be provided to release information publicly and the parties shall negotiate in good faith regarding whether such request can be accommodated.

Section 7.14 No Waiver.

(a) No delay on the part of either party in exercising any right under this Agreement will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.

Section 7.15 Confidential Information.

(a) EOHHS agrees that information that the MA Health Plan submits under this Agreement will be treated as non-public information to the extent permitted by law.

[Remainder of this page intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, authorized representatives of the parties execute this Agreement to be effective as of the Effective date:

Rhode Island Executive Office of Health & Human Services

By: Kristin Pono Sousa

Printed Name: Kristin Pono Sousa

Title: Medicaid Program Director

Date: 6/24/2022

Blue Cross Blue Shield of Rhode Island

By: DocuSigned by: Christina Pitney

Printed Name: Christina Pitney

Title: Sr. Vice President, Government Programs

Date: 06/13/22

APPENDIX A

MA HEALTH PLANS
APPLICABLE SERVICE AREAS AND
DUAL ELIGIBLE AND OTHER DUAL ELIGIBLE CATEGORIES

Contract Number	PBP	Plan Name	Eligible Category	Service Area
H4152	021	BlueRI for Duals (HMO D-SNP)	FBDE, SLMB Plus, QMB Plus, QMB	Bristol, Kent, Newport, Providence, Washington

APPENDIX B

MEDICAID BENEFITS COORDINATED BY MA HEALTH PLAN

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 Contractor's 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 as needed, 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 as needed, based on medical necessity, including primary care, specialty care, obstetric and newborn care. Up to one (1) annual and five (5) gynecology visits annually to a network Health Care Professional for Family planning is covered without a PCP referral.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by a Health Care Professional. Limited to prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*.
Non-Prescription Drugs	Covered when prescribed by a Health Care Professional. 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 Care Professional including urine drug screens.
Radiology Services	Covered when ordered by a Health Care Professional.
Diagnostic Services	Covered when ordered by a Health Care Professional.
Mental Health and Substance Use Disorder Treatment-Outpatient/Inpatient	Covered as needed for all members. Covered services include a full continuum of Mental Health and Substance Use Disorder (MH/SUD) treatment, including but not limited to: community-based narcotic treatment, methadone, and community- or hospital-based 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"). Also includes, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs; Assertive Community Treatment (ACT); as described in in the following State documents: Integrated Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; Integrated Health Home (IHH) as described in the following State documents: Integrated

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including, but not limited to:
	Health Homes Rhode Island SMI Program Description and Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual; and services for individuals at CMHCs.
Home Health Services	Covered services include those services provided under a written plan of care authorized by a Health Care Professional; 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. Home Health services should not prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home Health services cannot be limited to services furnished to beneficiaries who are homebound.
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, personal care services, and Personal Emergency Response (PERS)
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Care Professional, or in order to assess whether a condition warrants treatment as an Emergency Service.
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician/provider. All skilled and custodial care covered.
Services of Other Practitioners	Covered if referred by a Health Care Professional. 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 Abuse Treatment – 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 Contractor may conduct utilization review on the length of stay. The Contractor must offer appropriate transitional Care Management to persons upon discharge and coordinate and/or arrange for in-plan Medically Necessary

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including, but not limited to:
	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.
Court-Ordered Mental Health and Substance Abuse Treatment – Civil Court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. Contractor must follow all regulations promulgated pursuant to the R.I. Gen Laws §40.1-1 et seq., Behavioral Healthcare, Developmental Disabilities and Hospitals, and R.I. Gen Laws § 40.1-5 et seq.,, Mental Health Law, including R.I. Gen Laws §40.1-5.5 et seq. The Contractor 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 Children's Hospital), 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 seven (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 fourteen (14)-day prior authorization requirement for residential treatment as defined in SECTION 2.12.03.02.
Podiatry Services	Covered as ordered by Health Care Professional.
Optometry Services	Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two (2) years. Eyeglass lenses are covered more than once in two (2) years only if medically necessary. Eyeglass frames are covered only every two (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:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an inpatient setting.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including, but not limited to:
	Outpatient: Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by an Enrollee in an outpatient hospital setting. *Oral Surgery*: Treatment covered as Medically Necessary, as detailed in the *Schedule of In-Plan Oral Health Benefits.*
Hospice Services	Covered as ordered by a Health Care Professional. Services limited to those covered by Medicare.
Durable Medical Equipment (DME)	Covered as ordered by a Health Care Professional 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.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions and as referred by a Health Care Professional
Group/Individual Programs Education	Including healthy lifestyles/weight management, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Care Professional.
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. 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.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including, but not limited to:
AIDS Medical Case Management	Medical Care 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 Care 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 Care Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) Intake; 2) Assessment of service needs; 3) Development of a comprehensive ICP; 4) Coordination of services required to implement the ICP; 5) Monitoring the ICP to assess the efficacy of the plan; and 6) Periodic re-evaluation and adaptation of the plan as necessary over the time the Enrollee is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of Care Management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with Health Care Professional 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.

LONG TERM SERVICES AND SUPPORTS (LTSS) COORDINATED BY MA HEALTH PLAN

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including, but not limited to:
Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities
Meals on Wheels	The delivery of hot meals and shelf staples to the Enrollee's residence. Meals are available to Enrollees unable to care for their nutritional needs because of a functional dependency/disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.
Skilled Nursing Services (LPN Services)	LPN services provided under the supervision of a registered nurse. LPN services are available to Enrollees who require interventions beyond the scope of certified nursing assistant (CNA) duties. LPN services are provided in accordance with the nurse practice act under the supervision of a registered nurse. This service is aimed at Enrollees who have achieved a measure of medical stability despite the need for chronic care nursing interventions
Community Transition Services	Community transition services are non-recurring set-up expenses for Enrollees who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the Enrollee is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an Enrollee to establish a basic household that do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings, and moving expense; set-up fees or deposits for utility or service access; and services necessary for the Enrollee's health and safety and activities to assess need arrange for and procure needed resources. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the Community Transition Plan development process and clearly identified in the Community Transition Plan and the Enrollee is unable to meet such expense or when the services cannot be obtained from other sources. They do not include ongoing shelter expenses, food, regular utility charges, household appliances, or items intended for recreational purposes
Residential Supports	Assistance with acquisition, retention, or improvement in skills related to ADLs, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the Enrollee to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of

	facility maintenance (where applicable), or upkeep and improvement.
Day Supports	Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the Enrollee to attain or maintain his/her maximum functioning level and are coordinated with any other services identified in the Enrollee's LTSS Care Plan.
Supported Employment	Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.
RIte @ Home (Supported Living Arrangements-Shared Living)	Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported living arrangements are furnished to Enrollees who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an Enrollee receiving supported living arrangements, since these services are integral to and inherent in the provision of adult foster care services.
Private Duty Nursing	Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the LTSS Care Plan. These services are provided to an Enrollee at home.
Supports for Consumer Direction (Supports Facilitation)	Focuses on empowering Enrollees to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the Enrollee through the service planning and delivery process. The facilitator counsels, facilitates, and assists in development of a self-directed care plan which includes both paid and unpaid services and supports designed to allow the Enrollee to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the self-directed care plan are temporarily unavailable.
Self-Directed Goods and Services (self-directed care)	Self-directed goods and services are services, equipment or Supplies not otherwise provided through LTSS or through the Medicaid State Plan that address an identified need and are in the approved self-directed care plan (including improving and maintaining the Enrollee's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services and/or promote inclusion in the community; and/or the item or service would increase the Enrollee's ability to perform ADLs or IADLs and/or increase the person's safety in the home environment; and, alternative funding sources are not available. Individual goods and services are purchased from the Enrollee's self-directed budget through the fiscal intermediary when approved as part of the self-directed care plan. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the Enrollee or strictly experimental in

	nature.
Financial Management Services (Fiscal Intermediary)	Payroll services for self-directed care program Enrollees; responsible for all taxes, fees, and insurances required for the self-directed care program Enrollee to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made comply with the Enrollee's approved spending plan and conduct criminal background and abuse registry screens of all Enrollee's employees.
Senior Companion (Adult Companion Services)	Non-medical care, supervision and socialization, provided to a functionally impaired adult Enrollee. Companions may assist or supervise the Enrollee with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Companions may also perform light housekeeping tasks, which are incidental to the care and supervision of the Enrollee. This service is provided in accordance with a therapeutic goal in the LTSS Care Plan.
Assisted Living	Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to Enrollees who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to Privacy. Living units may be locked at the discretion of the Enrollee, except when a physician or mental health professional has certified in writing that the Enrollee is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with ire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The Enrollee retains the right to assume risk, tempered only by the Enrollee's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each Enrollee to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible and treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.
Personal Care Assistance Services	Provide direct support in the home or community to Enrollees in performing tasks they are functionally unable to complete independently due to disability, based on the LTSS Care Plan and/or the self-directed care plan. Services include:

	• Enrollee assistance with ADLs, such as grooming, personal hygiene, toileting bathing, and dressing • Assistance with monitoring health status and physical condition • Assistance with preparation and eating of meals (not the cost of the meals itself) • Assistance with housekeeping activities (e.g., bed making, dusting, vacuuming, laundry, grocery shopping, cleaning) • Assistance with transferring, ambulation, and use of special mobility devices • Assisting the Enrollee by directly providing or arranging transportation (If providing transportation, the personal care assistant must be verified as having a valid driver's license and liability coverage).
Respite	Respite can be defined as a service provided to Enrollees unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Enrollee. Federal financial participation is not claimed for the cost of room and board as respite services are provided in a private home setting, which may be in the Enrollee's home or occasionally in the respite provider's private residence, depending on Family preference and case-specific circumstances. When an individual is referred to a RI EOHHS-certified respite agency, a respite agency staff person works with the Family to assure they have the requisite information and/or tools to participate and manage the respite services, The Enrollee/Family will already have an allocation of hours that has been recommended and approved by RI EOHHS. These hours will be released in six (6) month increments. The Enrollee/Family will determine how they wish to use these hours. Patterns of potential usage might include: intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the Family to spend a few Days together; or some combination of the above. The Enrollee's/Family's plan will be incorporated into a written document that will also outline whether the Enrollee/Family wants help with recruitment, the training needed by the respite worker, the expectations of the Enrollee/Family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each eligible Enrollee may receive up to one hundred (100) hours of respite services in a year.
Rehabilitation Services	Physical, occupational and speech therapy services may be provided with Health Care Professional orders by RIDOH licensed outpatient rehabilitation centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the Enrollee requires specialized rehabilitation services not available from a home health or outpatient hospital provider.