Neighborhood Health Plan of Rhode Island

Amendment No. 5

THIS AMENDMENT NO. 5, is made and entered into the 1st day of July, 2021 between the State of Rhode Island, (formerly known as State of Rhode Island and Providence Plantations) Executive Office of Health and Human Services (hereinafter called "EOHHS") and Neighborhood Health Plan of Rhode Island (hereinafter called "Contractor").

WHEREAS, EOHHS and Contractor entered into a Medicaid Managed Care Services Agreement (hereinafter called the "Agreement") dated March 1, 2017.

WHEREAS, the original Agreement identified above, together with any and all previously executed amendments, and all its terms and conditions remain unchanged except as modified in this Amendment No 5.

NOW THEREFORE, EOHHS and Contractor hereby agree that the Agreement shall be amended as follows:

ARTICLE I: DEFINITIONS

1. **Section 1.01 ABUSE** is amended by ***DELETING*** and ***REPLACING*** the definition in its entirety with the following definition, "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."

2. **Section 1.04 ACTUARY** is amended by ***DELETING*** the last sentence in the section in its entirety. Section is further amended by ***DELETING*** and ***REPLACING*** the first sentence with the following, "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."

3. **Section 1.07 Adverse Benefit Determination** is amended by ***DELETING*** and ***REPLACING*** the definition in its entirety with the following definition, "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."

4. **Section 1.11 APPEAL** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following definition, "A review by an MCO, PIHP, or PAHP of an adverse benefit determination, that is in accordance with 42 C.F.R. § 438.400."

5. **Section 1.12 CAPITATION PAYMENT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following definition, "In accordance with 42 C.F.R. § 438.2, a 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."

6. **Section 1.13 CARE COORDINATION** is amended by ***DELETING*** the first sentence of the definition and ***REPLACING*** with the following, "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."

7. **Section 1.14 CARE MANAGEMENT** is amended by ***DELETING*** the last sentence in the definition and ***REPLACING*** with the following, "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"

8. **Section 1.15 CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND (CTC-RI)** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

9. **Section 1.16 CASE MANAGEMENT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

10. **Section 1.18 CHOICE COUNSELING** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following definition, "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."

11. **Section 1.20 COLD CALL MARKETING** is amended by ***DELETING*** and ***REPLACING*** the CFR citation with the following corrected CFR citation, "42 C.F.R. § 438.104".

12. **Section 1.21 COMMUNITY HEALTH TEAM** is amended by ***DELETING*** and ***REPLACING*** the first sentence with the following definition, "A health care program to assist members in obtaining care and services needed."

13. **Section 1.22 COMPREHENSIVE RISK CONTRACT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

14. **Section 1.28** is amended by ***INSERTING*** the following definition, "**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." Subsequent sections are renumbered.

15. **Section 1.29 DEEMED NEWBORN ELEGIBILITY** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

16. **Section 1.30 DURABLE MEDICAL EQUIPMENT** is amended by ***INSERTING*** 'equipment' into the first sentence, "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."

17. **Section 1.32 EMERGENCY MEDICAL CONDITION** is amended by ***DELETING***, the definition in its entirety and ***REPLACING*** with the following, "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."

18. **Section 1.36 EMERGENCY SERVICES** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

19. **Section 1.37 EMERGENCY SERVICES/EMERGENCY MEDICAL CONDITION** is ***DELETED*** in its entirety. Subsequent sections are renumbered.

20. **Section 1.37 ENROLLEE** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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'."

21. **Section 1.38 ENROLLEE ENCOUNTER DATA** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

22. **Section 1.39 EPSDT** is amended by ***DELETING*** the section in its entirely and ***REPLACING*** with the following "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."

23. **Section 1.41 EXCLUDED SERVICES** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "Refer to services not covered by the Medicaid State Plan – see Attachment C, NON-COVERED SERVICES.".

24. **Section 1.44 FRAUD** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

25. **Section 1.45 GRIEVANCE** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

26. **Section 1.46** is amended by ***INSERTING*** the following definition, "**Section 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." Subsequent sections are renumbered.

27. **Section 1.47 HABILITATION SERVICES** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

28. **Section 1.49 HEALTH CARE PROFESSIONAL** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "**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."

All references to "Health Care Professional" have been ***DELETED*** and ***REPLACED*** with the words, "Health Care Provider" in the Agreement.

29. **Section 1.60 HOME HEALTH SERVICES** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "Home Health Services are those services as defined in 42 C.F.R. § 440.70."

30. **Section 1.67 INDIAN** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

31. **Section 1.68 INDIAN PROVIDER, SERVICE, INCLUDING CHCs OPERATED BY THE INS OR BY AN INDIAN TRIBE/ORGANIZATION, OR URBAN INDIAN ORGANIZATION** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "**INDIAN HEALHCARE 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)."

32. **Section 1.69** is amended by ***INSERTING*** the following definition, **"Section 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." Subsequent section are renumbered.

33. **Section 1.70 INTENSIVE CARE MANAGEMENT PLAN** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

34. **Section 1.71 LIMITED ENGLISH PROFICIENT (LEP)** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

35. **Section 1.72 LONG-TERM SERVICES AND SUPPORT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

36. **Section 1.73 MARKETING** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

37. **Section 1.74 MARKETING MATERIALS** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "In accordance with 42 C.F.R. §438.104,marketing materials 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.

38. **Section 1.75 MATERIAL ADJUSTMENT**, is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

39. **Section 1.76 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

40. **Section 1.79 NETWORK** is amended by ***ADDING*** the words, "subcontractors" after the word "Providers" in sentence number one.

41. **Section 1.80 NETWORK PROVIDER** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

42. **Section 1.82, NON-PARTICIPATING PROVIDER** is amended by ***DELETING*** the last sentence in its entirety from the definition.

43. **SECTION 1.83 NON-RISK PAYMENT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

44. **Section 1.84 OVERPAYMENT** is amended by ***ADDING*** the following to the first sentence of the definition, "In accordance with 42 C.F.R. § 38.2, an".

45. **Section 1.93 POST-STABILIZATION CARE SERVICES**, is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

46. **Section 1.94 POTENIAL ENROLLEE** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

47. **Section 1.95 PRE-AUTHORIZATION** is amended by ***ADDING*** after "Pre-Authorization" the following "Prior Authorization or Precertification" to the title of the definition.

    The section is also amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

48. **Section 1.96 PREMIUM** is amended by ***DELETING*** the section in its entirety and ***REPLACING*** it with the following, "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."

49. **Section 1.98 PREPAID INPATIENT HEALTH PLAN** is amended by ***DELETING*** the section in its entirety and ***REPLACING*** it with the following, "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."

50. **Section 1.101 PREVALENT** is amended by ***DELETING*** the section in its entirety and ***REPLACING*** with the following, "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."

51. **Section 1.103 PRIMARY CARE PHYSICIAN** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** all references within the contract with the words, "**PRIMARY CARE PROVIDER**". The definition is amended by ***DELETING*** in its entirety and ***REPLACING*** with the following , "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."

52. **Section 1.104 PRIVATE DUTY NUSRING** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

53. **Section 1.105 PROVIDER** is amended by ***DELETING*** the section in its entirety and ***REPLACING*** with the following, "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."

54. **Section 1.107 RATE CELL** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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.

55. **Section 1.108 RATING PERIOD** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

56. **Section 1.110 REHABILITATION SERVICES,** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

57. **Section 1.114 RISK CONTRACT** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

58. **Section 1.115 RISK CORRIDOR** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** with the following, "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."

59. **Section 1.126, STABILIZED** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

60. **Section 1.28** is amended by ***INSERTING*** the following definition, "**Section 1.128 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." Subsequent sections are renumbered.

61. **Section 1.133 STOP LOSS** definition has been ***DELETED*** in its entirety. Subsequent sections have been renumbered. STOP LOSS has been removed from the entirety of the agreement.

62. **Section 1.128 SUBCONTRACTOR** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "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."

63. **Section 1.130 TELEHEALTH SERVICES,** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following new definition, "**Section 1.131 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."

64. ***ADDING*** a new definition, "**Section 1.135 WASTE**, The overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system."

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

65. **Section 2.01.01.01 Alternative Payment Methodologies** is amended by ***INSERTING*** a new paragraph to the end of the section to read as follows, "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."

This section is also amended by ***DELETING*** 'Rhode Island Executive Office of Health and Human Services "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" and ***REPLACING*** with "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners."

66. **Section 2.01.01.01.01 Capitation Withhold and Adjusting Payments** is amending by ***DELETING*** and ***REPLACING*** 'Rhode Island Executive Office of Health and Human Services "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" and ***REPLACING*** with "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners."

The second paragraph of this section, first sentence, is amended by ***DELETING*** and ***REPLACING*** 'reporting calendar' with 'Reporting Calendar.'

67. **Section 2.01.01.02 Accountable Entities** is amending by ***DELETING*** the second paragraph and ***REPLACING*** with the following:
"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

68. **Section 2.03.02, Other Administrative Components** is amended by ***ADDING*** a new bullet after the last bullet as follows,

- "Privacy and Security Officer"

69. **Section 2.04.01.01 Five Base RIte Care Eligible Groups** is amended by adding "(5)" after 'five' in the first sentence of the section.

70. **Section 2.04.12 Automatic Assignment to Health Plans** is amended by ***ADDING*** the words, "In accordance with 42 C.F.R. §438.54, EOHHS shall employ a formula" at the beginning of the section paragraph.

71. **Section 2.05.01 Health Plan Marketing** is amended by ***DELETING*** sentence seven in section paragraph and ***REPLACING*** with the following, "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)."

72. **Section 2.05.02 Health Plan Enrollment Procedures** is amended by ***REVISING*** the fourth paragraph, sentence one, with the following, "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)."

73. **Section 2.05.02.03 Enrollment of Uninsured Children up to Age Eighteen Above 250 Percent of the Federal Poverty Level (Related Group)** is amended by ***REMOVING*** the last two sentences in the section.

74. **Section 2.05.03 Change in Status** is amended by ***REMOVING*** the last two sentences of the section.

Section is amended by ***ADDING*** to the last sentence in paragraph two, "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."

75. **Section 2.05.10.01 Required Information** is amended by ***REVISING*** the federal citations in various bulleted sections as follows:

Information on Advance Directives:

(1) ***DELETING*** "42 CFR 438.6(i)(2)iv" and ***REPLACING*** with "42 C.F.R. §438.3(j)"

(2) ***DELETING*** "42 CFR 438.6(i)(4)" and ***REPLACING*** with "42 C.F.R. §438.3(j)(4)"

Information on formal grievance, appeal and fair hearing procedures:
DELETING "42 CFR 438.10(g)(1) and ***REPLACING*** with "42 C.F.R. §438.3(g)(2)(xi)"

Written notice of significant changes in enrollee rights:

REVISING "42 CFR 438.10(f)(4)" and ***REPLACING*** with "42 C.F.R. §438.3(g)(4)"

REMOVING from the last sentence, 'the Secretary' and ***REPLACING*** with "EOHHS."

76. **Section 2.06.01.03 Behavioral Health Services** is amended by ***REVISING*** with 'Non-Quantitative' in the second paragraph, second sentence and third sentence.

Section is further amended by ***DELETING*** 'EOHHS Reporting Calendar Templates' and ***REPLACING*** with "EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance".

77. **Section 2.06.01.07 Telehealth** is amended by ***INSERTING*** the following, "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)."

78. **Section 2.06.01.10 In Lieu of Services** is amended by ***DELETING*** the last sentence of paragraph one of the section and ***REPLACING*** with the following, "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*."

Section is amended by ***DELETING*** the bullet under paragraph three and ***REPLACING*** it with the following new bullet, "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)."

Section is amended by ***DELETING*** and ***REPLACING*** the last sentence of paragraph one of the section with the following, "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."

79. **Section 2.06.03 Second Opinion** is amended by ***DELETING*** the paragraph in its entirety and ***REPLACING*** it with the following new paragraph, "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.

80. **Section 2.07.06 Rhode Island Department of Health** this section is amended by ***DELETING*** the words, "Disability and Health Program" in the second sentence and ***REPLACING*** it with, "Office of Special Health Care Needs".

81. **Section 2.07.10 Dental Services** is amended by ***INSERTING*** the words, "and young adults" after the word, "children" at the end of the last sentence.

82. **Section 2.08.01 Network Composition** is amended by ***REVISING*** the language in bullet six of paragraph ten with the following new language, "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;"

83. **Section 2.08.02.02 Operational Requirements for Management of APM Subcontracts with Accountable Entities** is amended by ***DELETING*** 'RI EOHHS Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners' and ***REPLACING*** with "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" in all sections.

    Section is further is amended by ***DELETING*** and ***REPLACING*** with the following, "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."

84. **Section 2.08.02.03 HSTP and the Medicaid Infrastructure Incentive Program** is amended by ***DELETING*** in the last paragraph typo from 'anually' and ***REPLACING*** with 'annually."

85. **Section 2.08.02.04 Development, Implementation, and Oversight of the AEIP Program** is amended ***DELETING*** and ***REPLACING*** with "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" in section.

86. **Section 2.08.02.05 MCO Incentive program Management Pool (MCO-IMP)** is amended ***DELETING*** and ***REPLACING*** with "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" in section.

87. **Section 2.08.06 Children's Behavioral Health Services** this section is amended by ***ADDING*** the words, "See Attachment O for further information" after the last sentence.

88. **Section 2.08.10 Department of Health Laboratory** this section is amended by ***DELETING*** the paragraph in its entirety and ***REPLACING*** it with the following, "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."

89. **Section 2.09.03 Emergency Medical Services** is amended by ***REPLACING*** the federal citation in paragraph one, sentence three as follows, "42 CFR 438.114(d((1)(I)" to "42 C.F.R. § 438.114(d)(1)(i)".

The section if further amended by ***REPLACING*** the federal citation in paragraph one, sentence four as follows, "42 C.F.R. § 438.114(b)" to "42 C.F.R. § 438.114(d)(3)".

90. **Section 2.09.05 Post-Stabilization Care Services** is amended by ***REPLACING*** the federal citations in paragraphs one and three as follows, "42 CFR 422.133(c)" to "42 C.F.R. §422.113(c)".

91. **Section 2.10.03 Annual Notification** is amended by ***REPLACING*** federal citations as follows:
    - Paragraph one, bullet five from, "42 C.F.R. § 438.10(g)(1)" to "42 C.F.R. §438.10(g)(2)"
    - Paragraph one, bullet fourteen, from "42 CFR 438.6(I)(1) to "42 C.F.R. §438.3(j)";
    - Paragraph one, bullet fifteen from, "42 CFR 438.206" to "42 C.F.R. §438.3(i), § 422.208 and §422.210"

92. **Section 2.12.02 Medical Director's Office** is amended by ***REPLACING*** the federal citations in bullet five of paragraph two as follows "42 CFR 447.26, 42 CFR 447,434,438, and 1902(a)(4)[i], 1902(a)(6)[i], and 1903[ii]" to "42 C.F.R. §447.26, 434.6(a)(12), 438.3(g), and Section 2703 of the Patient Protection and Affordable Care Act."

93. **Section 2.12.03.02 Utilization Review** is amended by ***REPLACING*** the federal citation in paragraph fourteen, bullet one as follows, from "42 CFR 438.10(c)" to "42 C.F.R. § 438.10(a)".

Section is further amended by ***INSERTING*** the following at the end of the section, "Contractor must comply with Treatment of Hepatitis C Prior Authorization Guidelines authorized on March 1, 2021 by EOHHS."

94. **Section 2.12.03.02.01 Drug Utilization Review** this section is amended by ***DELETING*** the first sentence in paragraph one and ***REPLACING*** it with the following new language, "The Contractor must operate a Drug Utilization Review Program (DUR) that complies with the requirements described in section 1927(g) of the Social Security Act. In addition, the Contractor must comply with 42 C.F.R. part 456, Subpart K, as if the requirements applied to the Contractor instead of the State."

This section is further amended by **REPLACING** paragraph two with the following new language, "The Contractor is required to comply with the SUPPORT for Patients and Communities Act, Title 1, Section 1004 (2018), as codified in Sections 1902 and 1932 of the Social Security Act, which mandates the following:"

This section is further amended by ***ADDING*** language to the beginning of bullet two of the third paragraph as follows. "In accordance with 42 C.F.R. §438.3(s)(5),".

This section is further amended by ***REVISING*** the first sentence of paragraph four as follows, "In accordance with 42 C.F.R. §438.3(s)(6) and Section 1927(d)(5) of the Social Security Act, the".

95. **Section 2.13.01 General** is amended by ***DELETING*** the first paragraph in its entirety and ***REPLACING*** with the following, "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."

Section is further amended by ***REVISING*** the federal citation from, "42 U.S.C. § 300(k)(k)" to "42 U.S.C. §300kk."

96. **Section 2.13.02.04 Data Validation** is amended by ***INSERTING*** the following language to end of the section, "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*."

97. **Section 2.13.03 Grievance and Appeals Data** is amended by ***DELETING*** the first paragraph in its entirety and ***REPLACING*** with the following, "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."

Section is further amended by ***REPLACING*** the first sentence of paragraph two as follows, "In accordance with 42 C.F.R. §438.416, the Contractor will provide the following with each record of a grievance or appeal:".

98. **Section 2.13.07.01 Member Fraud and Out of State Report** is amended in its entirety by ***DELETING*** and ***REPLACING*** with the following, "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*."

99. **Section 2.13.08.01 Recovery Reporting** is amended by ***DELETNG*** the first sentence it its entirety and ***REPLACING*** it as follows, "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."

100. **Section 2.13.11 Certification of Data** is amended by ***DELETING*** the first sentence in its entirety and ***REPLACING*** it as follows, "The Contractor agrees to certify data in accordance with 42 C.F.R. §438.606."

Section is amended by ***ADDING*** the following sentence to the end of the section, "Certification of data policy and procedures are outlined in *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Non-Compliance*."

101. **Section 2.14.01 General** is amended by ***DELETING*** sentence two of paragraph one and ***REPLACING*** it as follows, "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.

This section is further amended by ***REVISING*** sentence one of paragraph three as follows, "In accordance with 42 C.F.R. §438.416, the record of each grievance must contain, at a minimum, all the following information:".

102. **Section 2.14.02 Adverse Benefit Determination** is amended by ***DELETING*** the first paragraph in its entirety.

This section is further amended by ***REVISING*** sentence number one of paragraph two to read as follows, "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:"

REVISING paragraph four, sentence five, "42 CFR 438.404(c)" to "42 C.F.R. §438.404(c)"

103. **Section 2.14.05 Continuation of Benefits** is amended by ***REPLACING*** bullet number two, paragraph one, with the following new language, "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;"

This section is further amended by ***REPLACING*** bullet one in paragraph two with the following new language, "The member withdraws the appeal or requests a state fair hearing;".

104. **Section 2.15.01 Acceptance of State Capitation Payments** is amended by ***REVISING*** the following, from "1/301h" to "1/30th."

105. **2.15.01.01 Fee Schedule Increase and Adoption of Minimum/Maximum Fee Schedule** is amended by ***DELETING*** the section in its entirety, and ***REPLACING*** with section "**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.

106. **Section 2.15.01.12, Physician Incentive Plans** is amended by ***ADDING*** a new last sentence as follows, "In accordance with 42 C.F.R. § 438.3(i)".

107. **Section 2.15.03 Stop Loss** is amended by ***DELETING*** the section entirely. Subsequent section are renumbered.

108. **Section 2.15.11 Prohibited Payments** is amended by ***REVISING*** the federal citation as follows, from "42 U.S.C. § 1396(i)" to "42 U.S.C. §1396b(i)."

109. **Section 2.16.03 Financial Data Reporting** is amended by ***DELETING*** the fifth and tenth bullet points from the section.

     Section is further amended by ***INSERTING*** an eleventh bullet point, "Financial Data Cost Report."

110. **Section 2.16.03.01 Financial Data Reporting System** is amended by ***DELETING*** the section in its entirety. Subsequent sections are renumbered.

111. **Section 2.18.01 General Requirements** is amended by ***INSERTING*** five new bullets after the last bullet in the section as follows,
     - "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 the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the EOHHS program integrity unit 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."

112. **Section 2.18.02 Prohibited Affiliations with Individuals Debarred by Federal Agencies** is amended by ***DELETING*** and ***REPLACING*** the second paragraph of the section with the following, "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."

113. **Section 2.18.04 Disclosure by Providers: Information on Ownership and Control** is amended by ***REVISING*** the federal citation as follows, from "42 C.F.R. Section 1001.1001(a)(2)" to "42 C.F.R. Section 1001.2."

114. **Section 2.18.07 Disclosure Made by Providers to the Contractor** is amended by

    REVISING the federal citations as follows:

    In (A), change "1182(b)(1), (2), or (3)" to "1128(b)(1) through (3)" of the SSA.

    In (B), change "1129A" to "1128A" of the SSA.

    In paragraph two, change "42 C.F.R. 1001.1001" to "42 C.F.R. Section 1001.2"."

ARTICLE III: CONTRACT TERMS AND CONDITIONS

115. **Section 3.05.05, Subcontracts and Delegation of Duty** is amended by ***REVISING*** the federal citation in paragraph eight as follows, from "42 C.F.R. § 438.10(g)(1) "to "42 C.F.R. §438.10(g)(2)(xi)".

This section is further amended by ***REVISING*** paragraph eight after the federal citation to read as follows, "the Contractor agrees to inform providers and subcontractors, at the time they enter into a contract, about these requirements including but not limited to the following;"

116. **Section 3.07.03.01, General Requirements** is amended by ***DELETING*** paragraph three and all bullets in the section and ***REPLACING*** with the following, "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."

117. **Section 3.07.03.04 Recipient Verification Procedures** is amended by ***DELETING*** the first sentence of paragraph one and ***REPLACING*** with the following, "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."

118. **3.07.04.05 Types of Intermediate Sanctions** is amended by ***DELETING*** item number four entirely and ***REPLACING*** it with the following, "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."

119. **3.09.01 Maintaining Confidentiality of Information** is amended by ***ADDING*****,** "and 164" to the end of the HIPAA citation in paragraph eight, sentence number one. The new HIPAA citation will read as follows, "HIPAA 45 C.F.R. Part 160 and 164".

120. **3.11.01 Environmental Protection** is amended by ***REVISING*** the federal citation for the Clean Air Act as follows, from "42 U.S.C. 1857(h)" to "42 U.S.C. 7606" and ***DELETING*** the federal citation for the Environmental Protection Agency "40 CFR, Part 15."

ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS

121. Outpatient Hospital Services, ***DELETING*** 'as needed,' from the table description.

122. Physician/Provider Services, ***DELETING*** 'as needed,' from the table description.

123. This attachment is amended by ***INSERTING*** the following to the end of the attachment's table:

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.

ATTACHMENT B: SCHEDULE OF OUT-OF-PLAN BENEFITS

124. Paragraph one, sentence two of attachment is amended by ***DELETING*** and ***REPLACING*** with the following, "The Contractor is expected to refer to and coordinate these services as appropriate."

ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2022

125. Attachment is amended by ***DELETING*** the Attachment in its entirety and ***REPLACING*** it with a new Attachment J titled, "State Fiscal year 2022 Risk Adjustment Medicaid Managed Care Program" dated August 12, 2021.

Neighborhood Health Plan
Risk Adjusted Rates

Rate Cell	January 2021 Enrollment	Effective Rate Less CTC PMPM	Adjusted Risk Score	Initial Risk Adjusted Rate	Initial Budget Neutrality Adjustment	Budget Neutral Risk Adjusted Rate	Vaccine Assessment PMPM	Adjusted CTC PMPM	Adjusted Premium Tax PMPM	Risk Adjusted Full Rate	Budget Neutrality Adjustment	Final Adjusted Rate	0.5% Withhold	Adjusted Rate Less Withhold	Baseline Medical Expense Less CTC	Adjusted Baseline Medical Expense
Rite Care																
RC - MF<1	3,331	$ 652.89	1.0000	$ 652.89	1.0000	$ 652.89	$ 0.00	$ 1.59	$ 13.36	$ 667.84	1.0001	$ 667.91	$ 3.34	$ 664.57	$ 594.13	$ 595.78
RC - MF 1-5	18,074	183.99	1.0009	184.16	1.0007	184.29	-	1.59	3.79	189.67	1.0001	189.69	0.95	188.74	167.43	169.31
RC - MF 6-14	32,282	173.18	1.0009	173.34	0.9996	173.27	-	1.59	3.57	178.43	1.0000	178.43	0.89	177.54	157.60	159.27
RC - M 15-44	11,572	249.44	0.9802	244.50	1.0001	244.52	1.51	0.66	5.03	251.72	1.0000	251.72	1.26	250.46	228.86	225.01
RC - F 15-44	28,739	401.55	0.9802	393.60	1.0009	393.95	2.49	0.27	8.10	404.81	1.0000	404.81	2.02	402.79	368.42	361.73
RC - MF 45+	6,102	598.09	0.9802	586.25	0.9972	584.61	3.18	-	12.00	599.79	1.0000	599.79	3.00	596.79	548.75	536.37
RC - EFP	1,226	18.22	1.0000	18.22	1.0000	18.22	-	-	0.37	18.59	1.0000	18.59	-	18.59	16.12	16.12
RC - SOBRA	n/a	13,339.02	1.0000	13,339.02	1.0000	13,339.02	-	-	272.22	13,611.24	1.0000	13,611.24	-	13,611.24	12,872.15	12,872.15
Rite Care - Composite	**101,326**	**$ 288.07**		**$ 284.62**		**$ 284.63**	**$ 1.07**	**$ 0.99**	**$ 5.85**	**$ 292.54**		**$ 292.55**	**$ 1.46**	**$ 291.09**	**$ 263.48**	**$ 261.32**
Children with Special Healthcare Needs																
CSHCN - Adoption Subsidy	1,614	$ 644.02	1.0120	$ 651.75	0.9999	$ 651.68	$ 0.12	$ 1.53	$ 13.33	$ 666.66	1.0001	$ 666.73	$ 3.33	$ 663.40	$ 576.40	$ 584.85
CSHCN - Katie Beckett	33	3,514.34	1.0498	3,689.35	1.0604	3,912.19	0.18	1.46	79.87	3,993.70	0.9999	3,993.30	19.97	3,973.33	3,215.63	3,580.77
CSHCN - SSI < 15	2,058	1,624.08	1.0498	1,704.96	0.9993	1,703.77	-	1.59	34.80	1,740.16	1.0000	1,740.16	8.70	1,731.46	1,486.03	1,560.53
CSHCN - SSI >= 15	1,498	1,256.77	1.0498	1,319.36	0.9949	1,312.63	1.33	0.73	26.83	1,341.52	1.0000	1,341.52	6.71	1,334.81	1,149.94	1,201.78
CSHCN - Substitute Care	2,819	844.22	1.0000	844.22	1.0000	844.22	0.78	1.32	17.27	863.59	1.0000	863.59	4.32	859.27	755.57	756.89
CSHCN - Composite	**8,022**	**$ 1,092.03**		**$ 1,126.74**		**$ 1,126.08**	**$ 0.55**	**$ 1.32**	**$ 23.02**	**$ 1,150.97**		**$ 1,150.98**	**$ 5.76**	**$ 1,145.23**	**$ 990.68**	**$ 1,023.14**
Medicaid Expansion																
ME - F 19-24	5,782	$ 316.63	0.9914	$ 313.91	1.0007	$ 314.13	$ 3.18	$ 0.00	$ 6.48	$ 323.79	1.0000	$ 323.79	$ 1.62	$ 322.17	$ 290.51	$ 288.21
ME - F 25-29	3,027	461.58	0.9914	457.61	1.0029	458.94	3.18	-	9.43	471.55	1.0000	471.55	2.36	469.19	423.50	421.08
ME - F 30-39	3,019	694.35	0.9914	688.38	1.0006	688.79	3.18	-	14.12	706.09	1.0001	706.16	3.53	702.63	637.07	632.03
ME - F 40-49	2,948	896.38	0.9914	888.67	0.9990	887.78	3.18	-	18.18	909.14	1.0000	909.14	4.55	904.59	822.43	814.54
ME - F 50-64	8,188	837.95	0.9914	830.74	0.9979	829.00	3.18	-	16.98	849.16	1.0000	849.16	4.25	844.91	768.82	760.61
ME - M 19-24	6,001	226.12	0.9914	224.18	1.0020	224.63	3.18	-	4.65	232.46	0.9999	232.44	1.16	231.28	207.46	206.07
ME - M 25-29	4,189	425.73	0.9914	422.07	1.0048	424.10	3.18	-	8.72	436.00	1.0000	436.00	2.18	433.82	390.61	389.11
ME - M 30-39	6,155	637.42	0.9914	631.94	1.0034	634.09	3.18	-	13.01	650.28	0.9999	650.21	3.25	646.96	584.83	581.71
ME - M 40-49	3,955	839.19	0.9914	831.97	1.0012	832.97	3.18	-	17.06	853.21	1.0000	853.21	4.27	848.94	769.96	764.26
ME - M 50-64	6,436	946.69	0.9914	938.55	0.9974	936.11	3.18	-	19.17	958.46	1.0000	958.46	4.79	953.67	868.59	858.88
ME - SOBRA	n/a	13,339.02	1.0000	13,339.02	1.0000	13,339.02	-	-	272.22	13,611.24	1.0000	13,611.24	-	13,611.24	12,872.15	12,872.15
Medicaid Expansion - Composite	**49,700**	**$ 629.85**		**$ 624.43**		**$ 624.48**	**$ 3.18**	**$ 0.00**	**$ 12.81**	**$ 640.47**		**$ 640.46**	**$ 3.20**	**$ 637.26**	**$ 577.89**	**$ 572.95**
Rhody Health Partners																
RHP - ID	531	$ 1,348.03	1.0288	$ 1,386.85	0.9971	$ 1,382.83	$ 3.18	$ 0.00	$ 28.29	$ 1,414.30	1.0000	$ 1,414.30	$ 7.07	$ 1,407.23	$ 1,246.93	$ 1,279.12
RHP - SPMI	1,365	3,089.01	1.0288	3,177.97	0.9993	3,175.75	3.18	-	64.88	3,243.81	1.0000	3,243.81	16.22	3,227.59	2,857.34	2,937.57
RHP - Other Disabled 21-44	1,935	1,215.98	1.0288	1,251.00	1.0032	1,255.00	3.18	-	25.68	1,283.86	1.0000	1,283.86	6.42	1,277.44	1,124.78	1,160.87
RHP - Other Disabled 45+	3,651	1,878.41	1.0288	1,932.51	0.9997	1,931.93	3.18	-	39.49	1,974.60	1.0000	1,974.60	9.87	1,964.73	1,737.53	1,787.03
RHP - Composite	**7,482**	**$ 1,890.31**		**$ 1,944.75**		**$ 1,944.81**	**$ 3.18**	**$ 0.00**	**$ 39.76**	**$ 1,987.75**		**$ 1,987.75**	**$ 9.94**	**$ 1,977.81**	**$ 1,748.54**	**$ 1,798.95**
All Populations - Composite	**166,530**	**$ 500.79**		**$ 501.19**		**$ 501.18**	**$ 1.77**	**$ 0.67**	**$ 10.28**	**$ 513.89**		**$ 513.90**	**$ 2.57**	**$ 511.33**	**$ 459.07**	**$ 460.11**

Notes:
1. January 2021 Enrollment reflects all members fully eligible as of January 2021, including those who were not scored.
2. SOBRA Payments are excluded for purposes of the illustrated January 2021 composites.
3. Values have been rounded.

ATTACHMENT L: RATE-SETTING PROCESS

126. This Attachment is amended by ***DELETING*** the Attachment in its entirety and ***REPLACING*** it with a new Attachment L State Fiscal Year 2022 Medicaid Managed Care Capitation Rate Certification dated August 9, 2021.

ATTACHMENT N: SPECIAL TERMS AND CONDITIONS

127. **Section 1, Definitions, 2. Attribution** is amended by ***DELETING*** the second sentence and ***REPLACING***, “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.”

128. **Section 1, Definitions, 8. Medical Expenses** is amended by ***DELETING*** the seventh bullet point.

129. **Section 2, Risk Share/Gain Share Agreement** is amended by ***DELETING*** from the 13th paragraph ‘Stop Loss Statements.

130. **Section 7, Payments to Certified Patient Centered Medical Homes** is amended by ***REVISING*** reference to ‘Attachment J: CONTRACTOR’S CAPITATION RATES SFY 2022.’

131. **Section 9, Stop-Loss Claiming** is amended by ***DELETING*** the section in its entirety.

ATTACHMENT O: MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY SERVICES FOR CHILDREN

132. Section Mental Health Parity, bullet number one is amended by ***DELETING*** the bullet point and ***REPLACING*** with the following, “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.”

ATTACHMENT P: BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

133. Attachment is amended by ***REVISING*** typo in section heading title with ‘BEHAVIORAL.”

134. **Section B, Subsection 8. General Outpatient**, last sentence is amended by ***DELETING*** and ***REPLACING*** the following, "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."

135. Attachment Section C. LONG TERM RESIDENTIAL PROGRAMS is amended by ***DELETING*** and ***REPLACING*** typo in section heading title with 'RESIDENTIAL."

ATTACHMENT U: CLAIMS BASED DATA ELEMENTS

136. Attachment is ***DELETED*** in its entirety and ***REPLACED*** with the following:

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)		

Claims Based Data Elements			
Field name/Description		**Source/field number**	
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	
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

Claims Based Data Elements			
Field name/Description		**Source/field number**	
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 Provider who administers the service on the claim		Box 01
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.		

Claims Based Data Elements			
Field name/Description		**Source/field number**	
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	
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 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			

Non-Claims Based Data Elements			
ELIGIBILITY FIELDS	**Description**	**Other**	
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

137. ATTACHMENT V: COVID-19 Public Health Emergency

Attachment is amended by ***DELETING*** and ***REPLACING*** with the following attachment:

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"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."

IN WITNESS HERETO, the parties have caused this Amendment to be executed under Seal by their duly authorized officers or representatives as of the day and year stated below:

STATE OF RHODE ISLAND:

SIGNATURE

BENJAMIN L. SHAFFER

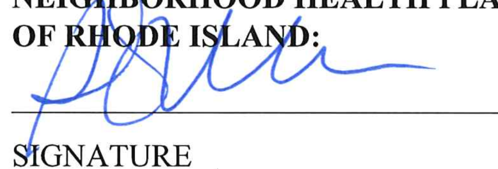
NAME

MEDICAID DIRECTOR

TITLE

DATE

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND:



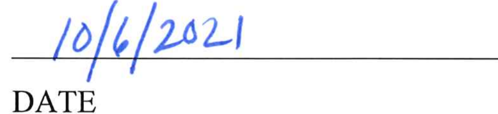
SIGNATURE

PETER MARINO

NAME

PRESIDENT & CEO

TITLE



DATE

Reviewed by
Legal - DDB