ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

ATTACHMENT A SCHEDULE OF IN-PLAN BENEFITS

Services below are covered for all members based on medical necessity criteria. Contractor is responsible for ensuring access and quality of care to services listed in Attachment A. Contractor shall provide services which increase the member's opportunities to remain at home and out of an institutional setting. Contractor is authorized to offer alternative services and value add services/equipment where such services are cost effective and clinically appropriate, including interventions intended to address social determinants of health.

Contractor will recognize that services in Attachment A entitled "scope of benefits" are provided as examples and do not represent an all-inclusive list of benefits.

Some services are subject to stop loss provisions as defined in section 1.97.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been disenrolled from 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.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Generic substitution only unless provided for otherwise as described in the *Managed Care Pharmacy Benefit Plan Protocols*.
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the *Medicaid Managed Care Pharmacy Benefit Plan Protocols*. Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.
Laboratory Services	Covered when ordered by a Health Plan physician/provider including urine drug screens.
Radiology Services	Covered when ordered by a Health Plan physician/provider.
Diagnostic Services	Covered when ordered by a Health Plan physician/provider.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Mental Health and Substance Use –Outpatient& Inpatient	Covered as needed for all members, as defined in ATTACHMENT O & ATTACHMENT P, including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Covered Services subject to limitations described in ATTACHMENT B. Also includes, DCYF ordered administratively necessary days (See Attachments O & P for further details), or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, and personal care services.
EPSDT Services	Provided to all children and young adults up to age 21(described in greater detail in Section 2.06.01.05 and ATTACHMENT E). Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as *medically* indicated. Includes multi-disciplinary evaluations and treatment, including, PT/OT/ST, for children with significant disabilities or developmental delays.
Emergency Room Service and Emergency Transportation Services	Covered both in- and out-of-State, for Emergency Services (2.10.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Nursing Home Care and Skilled Nursing Facility Care	Covered when ordered by a Health Plan physician/provider. For Rhody Health Partners/Expansion members, the Contractor payments are limited to thirty (30) consecutive days. Please refer to the Nursing Home Status Form Policy. All skilled and custodial care covered. Contractor is responsible for notifying the State to begin dis-enrollment process. For RIte Care members, please refer to stop-loss provisions as detailed in 1.122.
School-Based Clinic Services	Covered for RIte Care members as Medically Necessary at all designate sites.
Services of Other Practitioners	Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Court-ordered mental health and substance use services – criminal court	Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit: • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board. • Exclusions are presented in • ATTACHMENT B

Court-ordered mental health and substance use treatment – civil court	All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re- assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of: a) Voluntary Admission b) Emergency Certification c) Civil Court Certification Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 14-day prior authorization requirement for residential treatment as defined in SECTION 2.12.03.02.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Podiatry Services	Covered as ordered by Health Plan physician/provider.
Optometry Services	*For children under 21*: Covered as medically necessary with no other limits. *For adults 21 and older*: Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.
Oral Health	*Inpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting. *Outpatient:* Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting. *Oral Surgery:* Treatment covered as medically necessary. As detailed in the *Schedule of In-Plan Oral Health Benefits updated January 2017.*
Hospice Services	Covered as ordered by a Health Plan physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by a Health Plan physician/provider as medically necessary.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Adult Day Health	Day programs for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children's Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a registered or licensed dietitian for certain medical conditions as defined in ATTACHMENT D and as referred by a Health Plan physician.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Plan physician.
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required "steps" such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid's state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who require case management are entitled to receive it.) May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. Note: Does not involve coordination and follow up of medical treatments.
AIDS Medical Case Management	Medical Case Management services (including treatment adherence) are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include I) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to- face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Early Intervention	Covered for RIte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island Subject to stop loss greater than $5,000.
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider. See also EPSDT.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
In Lieu of Service	All services as provided in Attachment A can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
Neonatal Intensive Care Unit (NICU)	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from non-W&I NICU with admission to W&I for continued care.

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

ATTACHMENT B: SCHEDULE OF OUT-OF-PLAN BENEFITS

These benefits are not included in the capitated benefit. Contractor is expected to refer to and coordinate with these services as appropriate. These services will be provided by existing Medicaid-approved providers who will be reimbursed directly by the State on a fee-for-service or contractual basis. These benefits are not available to the following categories of RIte Care Eligible: (1) SOBRA-extension group with income above 250 percent of the FPL as described in Section Eligibility of Pregnant Women Under 250 Percent of the FPL *("SOBRA- Extension Group")*, (2) those receiving Extended Family Planning benefits as described in Section Eligibility of Extended Family Planning Group.

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Dental services Court-ordered mental health and substance use services ordered to a non-network facility or provider Non-Emergency Transportation Services (Non-Emergency transportation is coordinated by the contracted Health Plans). Nursing home services in excess of 30 consecutive days Residential services for MR/DD clients that are paid by the State's BHDDH Respite (Adult)

ELIGIBLE GROUP	BENEFIT(S) PROVIDED OUT-OF-PLAN
All Rhody Health Partners, RIte Care and Expansion members	Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital. Except as specified in Attachment A Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children Cedar Family Center Services Centers of Excellence Programs

ATTACHMENT C

SCHEDULE OF NON-COVERED SERVICES

ATTACHMENT C

SCHEDULE OF NON-COVERED SERVICES

- Experimental Procedures
- Abortion except to preserve the life of the woman, or in cases of rape or incest
- Private rooms in hospitals (unless medically necessary)
- Cosmetic surgery
- Infertility Treatment Services
- Medications for sexual or erectile dysfunction

ATTACHMENT D

RHODE ISLAND EPSDT PERIODICITY SCHEDULE

RHODE ISLAND EPSDT PERIODICITY SCHEDULE

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE									
	NEWBORN	3-5 DAYS	BY 1 MO	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	24 MO	30 MO	3 YRS	4 YRS	5 YRS	6 YRS	7 YRS	8 YRS	9 YRS	10 YRS	11 YRS	12 YRS	13 YRS	14 YRS	15 YRS	16 YRS	17 YRS	18 YRS	19 YRS	20 YRS
History																														
Initial/Interval	♦[1]	♦[1]	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Physical Examination																														
Physical Examination[2]	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Measurements																														
Length/Height and Weight	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Head Circumference	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦																		
Weight for Length	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦																				
Body Mass Index											♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Blood Pressure[3]	■	■	■	■	■	■	■	■	■	■	■	■	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Sensory Screening																														
Vision[4]	■	■	■	■	■	■	■	■	■	■	■	■	♦	♦	■	■	♦	■	♦	■	■	♦	■	♦	■	♦	■	♦	■	♦
Hearing[5]	♦[1]	■	■	■	■	■	■	■	■	■	■	■	♦	♦	■	■	♦	■	♦	■	■	♦	■	♦	■	♦	■	♦	■	♦
Developmental/Behavioral Assessment																														
Psychosocial/Behavioral Assessment	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Developmental Surveillance[7]	♦	♦	♦	♦	♦	♦		♦	♦		♦		♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Developmental Screening[8]							♦			♦		♦																		
Autism Screening[9]										♦	♦																			
Alcohol and Drug Use Assessment																					■	■	■	■	■	■	■	■	■	■
Procedures[10]																														
Newborn Screening[11]	♦																													
Immunization[12]	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Hematocrit or Hemoglobin					■			♦		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Lead Screening[13]						■	■	♦■		■	♦■		■	■																
Tuberculin Test[14]			■			■		■		■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Dyslipidemia Screening											■		■			■		■		■	■	■	■	■	■	■	■	◄	►	
Cervical Dysplasia Screening[15]																					■	■	■	■	■	■	■	■	■	■
STI Screening[16]																					■	■	■	■	■	■	■	■	■	■
Oral Health[17,18]						■	■	♦■		♦■	♦■	♦■	♦			♦														
Anticipatory Guidance[19]	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦	♦
Transition to Adult Services[20]																								◄						►

RHODE ISLAND REQUIRES THAT ALL CHILDREN, PRIOR TO SCHOOL ENTRY, RECEIVE VISION AND LEAD SCREENINGS AND BE UP TO DATE ON IMMUNIZATIONS.
SEE ABOVE SCHEDULE FOR RECOMMENDATION IN EACH AREA. PLEASE SEE SEPARATE SCHEDULE FOR THE RECOMMENDATION FOR PEDIATRIC ORAL HEALTH CARE.

♦ TO BE PERFORMED ■ PERFORM RISK ASSESSMENT WITH APPROPRIATE ACTION TO FOLLOW IF POSITIVE ◄► PERFORM WITHIN INDICATED TIME FRAME

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FOOTNOTES

1-Every infant should have a newborn evaluation at birth. Breastfeeding should be encouraged, with instruction and support offered.

2-Every infant should have an evaluation within 3 to 5 days of birth and within 72 hours after discharge, with instruction and support offered. For infants discharged less than 48 hours after delivery, the infant must be examined within 48 hours of discharge.

3-At each visit, an age-appropriate physical examination should be performed. Infants should be totally unclothed. Older children should be undressed and suitably draped.

4-Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3.

5-If the patient is uncooperative, rescreen within 6 months. See American Academy of Pediatrics Policy Statement. Eye Examination in Infants, Children, and Young Adults by Pediatricians. Pediatrics. 2003; 111(4):902-907. Available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902

6-Universal newborn hearing screening is required by RI Law.

7-Developmental surveillance consists of five components: eliciting and attending to parents' concerns about their child's development, documenting and maintaining a developmental history, making accurate observations about the child, identifying protective and risk factors, maintaining an accurate record and documenting the process and findings. Any concerns raised during developmental surveillance should be promptly addressed. For additional information, see references in footnote #8.

8-Use a standardized tool to identify children at risk of a developmental disorder. See American Academy of Pediatrics Policy Statement, Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. Pediatrics. 2006; 118:405-420. Available at: http://pediatrics.aappublications.org/cgi/content/full/118/1/405

9-Use a validated autism-specific standardized screening tool. See American Academy of Pediatrics Clinical Report, Identification and Evaluation of Children With Autism Spectrum Disorders. Pediatrics. 2007; 120(5):1183-1215. Available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;120/5/1183

10-Procedures may be modified, depending on a patient's entry point into the schedule and his/her individual needs.

11-Newborn Screening for metabolic, endocrine, and hemoglobin conditions is required by RI Law. The Rhode Island Newborn Screening Program will notify the primary care provider if repeat screening and follow-up is needed. For screening results or to confirm screening, call the Rhode Island Department of Health Information Line at 800-942-7434.

12-Assess immunization status at each visit and vaccinate according to the most current immunization schedule, available at http://www.health.ri.gov/immunization

13-Screen according to the RI Lead Screening & Referral Guidelines, available at http://www.health.ri.gov/lead/pdf/LeadGuidelines.pdf

14-Tuberculin testing should be done upon recognition of high-risk factors.

15-All sexually active girls should be screened for cervical dysplasia as part of a pelvic examination. Screening should start within 3 years of the onset of sexual activity or age 21, whichever comes first.

16-All sexually active patients should be screened for sexually transmitted infections (STIs).

17-Refer to dental home. Inform parents of Rite Smiles program for access to dental services, as needed. For information on Rite Smiles, visit http://www.dhs.ri.gov. If the primary water source is deficient in flouride, consider oral flouride supplementation.

18-At visits at ages 3 and 6, again stress importance of dental home. Inform parents of Rite-Smiles program, as appropriate. For Rite Smiles program information, see footnote #17. Consider oral flouride supplementation if primary water source is deficient in flouride.

19-Anticipatory Guidance refers to age-appropriate guidance to parents, adolescents, and children on topics such as injury and illness prevention, developmental surveillance and milestones, sexuality and substance abuse.

20-Transition Planning refers to equipping an adolescent and his/her family for the transfer from pediatric to adult health care by age 21. For healthcare transition resources, visit http://www.health.ri.gov/family/specialneeds/transition

ATTACHMENT E

RHODE ISLAND NUTRITION STANDARDS

I. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) – for Adults

1. Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) is required pursuant to screening routinely completed as part of periodic health exams as defined below:

SCREENING	STANDARD FOR REFERRAL TO RD, LDN
Weight Status*:	
Underweight	BMI ≤18.5
Overweight	BMI 25 – 29.9
Obesity	BMI ≥ 30
Unintended, Clinically Significant Weight Loss	Weight Loss ≥ 10% of Normal Body Weight
Blood Pressure	Diastolic ≥ 80 mm Hg Systolic ≥ 130 mm Hg
Fasting Blood Lipids	Cholesterol > 200 mg/dl LDL > 130 mg/dl (for individuals with diabetes, LDL > 100 mg/dl) HDL < 40 mg/dl TG > 150 mg/dl
Blood Glucose: Diabetes	Diagnosis of diabetes; A1C ≥ 6.5
Pre-Diabetes	Pre-diabetes; A1C between ≥ 5.8 and <6.5

* Weight Status Assessed Using Body Mass Index (BMI)

1. Referral to a RD, LDN is required as a result of a diagnosis of chronic disease, which can be managed, controlled, or ameliorated through Medical Nutrition Therapy, such as:

DISEASE/ CONDITION
Cardiovascular Disease
Hypercholesterolemia
Dyslipidemia
Chronic Renal Disease
Pulmonary Disease
Gastrointestinal Disease
Diabetes
Pre-Diabetes
Obesity
Eating Disorders
Hypertension
Autoimmune Disease
Anemia
Liver Disease/Hepatitis
HIV Positive/AIDS
Severe chronic food allergies
Phenylketonuria
Muscular-Skeletal Disease

2. Referral to a RD, LDN is also required under the following circumstances:

   a. Prescription regimen that has proven impact on nutrient absorption utilization and metabolism, i.e. Dilantin, Phenobarbital, MAO inhibitors, Coumadin, etc.
   b. Other conditions as medically necessary.

II. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) - Pregnant Women

1. Referral to a RD, LDN is required pursuant to screening routinely completed as part of normal obstetric care as defined by ACOG and detailed below:

Recommended Screening	Standard for Referral to a RD, LDN
Medical History:	
Past Pregnancy	History of Low Birth Weight (≤2500 grams), SGA, and/or premature infant (≤ 37 weeks GA) Macrosomia or LGA (≥4000 grams) Short Interpregnancy Interval
Current Pregnancy	Cardiovascular Disease/Disorders Renal Disease Pulmonary Disease Gastrointestinal Disease/Disorders Endocrine Disorders: Diabetes Mellitus, Gestational Diabetes Chronic/Gestational Hypertension Hypertensive Disorders including Pre-eclampsia/ Eclampsia Hypo/Hyperthyroidism Autoimmune Disease Anemia Liver Disease including Hepatitis Cancer Seizure Disorders Intrauterine Growth Retardation Multiple Pregnancy HIV Positive or AIDS Metabolic Disease Including Maternal Phenylketonuria Hyperemesis Gravidarum
Weight and Height:	
Pregravid Underweight Pregravid Overweight Pregravid Obesity	BMI* < 18.5 BMI 25.0-29.9 BMI > 30
Insufficient Weight Gain	First Trimester: Any weight loss during first trimester; Weight gain ≤ 3-5 lbs. /month for Pregravid under /normal. ≤ 2 lbs./month in second half of pregnancy

Recommended Screening	Standard for Referral to a RD, LDN
Excessive Weight Gain	Third Trimester: Weight gain ≤ 3 lbs. /month (for Pregravid underweight ≤ 4 lbs. /month; for Pregravid overweight/obese ≤ 2 lbs. /month). Weight Gain ≥ 6.5 lbs./month
Blood Pressure	Diastolic ≥90 mm Hg Systolic ≥140 mm Hg
Hemoglobin	1st Trimester 2nd Trimester 3rd Trimester <11.0 <10.5 <11.0

* Pregravid Weight Status Assessed Using Body Mass Index (BMI) = Wt. in lbs. / (Hot in Inches)^2

Note: GA- Gestational Age; SGA- Small for Gestational Age; LGA- Large for Gestational Age.

2. Referral to a RD, LDN is required under the following circumstances:

a. Age: ≤ 17 years or ≥ 35 years
b. Chronic/ Acute Under nutrition: Eating disorders such as anorexia and/or bulimia; restrictive eating patterns cultural practices and/or unusual dietary practices; substance use.
c. Severe chronic food allergies.
d. Prescription drug regimen that has proven impact on nutrient absorption, utilization, and metabolism.
e. Other conditions as medically necessary.

III. Criteria for Referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) - Children Age 0-21 Years

1. Referral to a RD, LDN is required pursuant to screening routinely completed as part of periodic health exams as defined by AAP and in the Guide to Clinical Preventive Services as detailed below:

SCREENING	STANDARD FOR REFERRAL TO A RD, LDN
HEIGHT AND WEIGHT	
Infants 0-12 Months:	Measure at all routine preventive visits.
Underweight	Weight for Length <25th percentile
Overweight	Weight for Length >85th percentile
Stunting	Length for Age <5th percentile or gross deviation from mid-parental height
Children 1-18 Years:	Measure bi-annually for children 1-2 years of age and annually for children 2-18 years of age.
Underweight	BMI <10th percentile
Overweight	BMI >85- 95th percentile
Obesity	BMI > 95th
Stunting	Length/Height for Age <5th percentile
Inappropriate Growth Pattern: Children 0 to 18 Years	Increase or decrease of more than 2 standard deviations (channels on growth chart) in established growth pattern.
Children 19-21:	
Underweight	BMI < 18.5
Overweight	BMI 25 – 29.9
Obesity	BMI ≥ 30
Hemoglobin: Screen at 6-9 months, 24 months, 8 years, and 18 years. More frequently when indicated.	Age Sex Hgb Level 6m-4 years both <11.0 g/dl 5-10 years both <11.5 g/dl 11-14 years both <12.0 g/dl 15-21 years females <12.0 g/dl 15-19 years males <13.0 g/dl 20-21 years males <13.5 g/dl
Lead Screening*	≥ 10 ug/dl
Hereditary or Metabolic Screening mandated by State Law: PKU,	Positive Test Results

SCREENING	STANDARD FOR REFERRAL TO A RD, LDN
Galactosemia, etc. Blood Pressure Children 3-6 years old, screen annually Children 8-21 years old, screen every other year Serum Cholesterol** 	Age Years / Diastolic / Systolic MM Hg MM Hg 3-5 / 76 / 116 6-9 / 78 / 122 10-12 / 82 / 126 13-15 / 86 / 136 Total Serum Cholesterol ≥170 mg/dl LDL ≥ 110 mg/dl

* See *Lead Screening & Referral Guidelines* on www.health.ri.gov under Lead Screening.

** Screen any child more than 2 years of age whose parent(s) or grandparent(s) have documented cardiovascular, peripheral vascular, cardiovascular disease before age 55 in males and before age 65 in females and/or a parent(s) have a total (fasting) serum cholesterol level ≥ 200 mg/dl

2. Referral to a RD, LDN is required as a result of diagnosis of chronic disease or condition, which can be managed, controlled, or ameliorated through therapeutic diet and nutrition counseling as detailed below:

DISEASE/ CONDITION
Cardiovascular Disease including Congenital Heart Disease Cancer Renal Disease Pulmonary Disease, including Cystic Fibrosis Gastrointestinal Disease Diabetes Pre-Diabetes Overweight Obesity Hypertension Liver Disease HIV/AIDS Metabolic Disorders including PKU

3. Referral to a RD, LDN is also required under the following circumstances:

a. Special health care needs carrying multiple nutrition risks including birth defects, neuromuscular disorders, developmental delays, and severe feeding problems.

b. Eating disorders such as anorexia and bulimia and cultural, unusual or bizarre eating practices that place child at medical or nutritional risk, i.e. PICA, diuretic or laxative use and/or self-induced vomiting to control weight, etc.

c. Severe chronic food allergies.

d. Prescription regimen that has proven impact on nutrient absorption, utilization, and metabolism.

e. Other conditions as medically necessary.

ATTACHMENT F

EXTENDED FAMILY PLANNING BENEFITS

ATTACHMENT F

SCHEDULE OF EXTENDED FAMILY PLANNING BENEFITS

The list below is approved as covered benefits for EFP members by the Centers for Medicare and Medicaid Services.

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
00851	Tubal ligation / transection	
11975	Insertion, implantable contraceptive capsules	
11976	Removal, implantable contraceptive capsules	✓
11977	Removal w/ reinsertion, implantable contraceptive capsules	
57170	Diaphragm or cervical cap fitting w/ instructions	
58300	Insertion of intrauterine device (IUD)	
58301	Removal of intrauterine device (IUD)	✓
58600	Ligation or transection of fallopian tubes	
58611	Ligation or transection of fallopian tubes	
58615	Occlusion of fallopian tubes by device	
58670	Laparoscopy, surgical; w/fulguration of oviducts (w/ or w/out transection)	
58671	Laparoscopy, surgical; w/occlusion of oviducts by device (e.g.: band, clip, etc.)	
81000	Urinalysis, by dipstick or reagent for bilirubin, glucose, hemoglobin, etc.	✓
81002	Urinalysis, non-automated without microscopy	✓
81003	Urinalysis, automated, without microscopy	✓
81005	Urinalysis; qualitative or semi qualitative, except immunoassays	✓
81007	Urinalysis, bacteriuria screen, except by culture or dipstick	✓
81015	Urinalysis, microscopic only	✓
81020	Urinalysis, two or three glass test	✓
81025	Urine pregnancy test, by visual color comparison methods	✓
85013	Blood count; spun micro hematocrit	✓

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
85014	Blood count; other than spun micro hematocrit	✓
85018	Blood count; hemoglobin	✓
86255	Fluorescent antibody; screen, each antibody	✓
86592	Syphilis test; qualitative (. g., VDRL, RPR, ART)	✓
86593	Syphilis test; quantitative	✓
86631	Antibody; Chlamydia	✓
86632	Antibody; Chlamydia, IgM	✓
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)	✓
86694	Antibody; herpes simplex, non-specific type test	✓
86695	Antibody, herpes simplex, type 1	✓
86701	Antibody; HIV-1	✓
86702	Antibody; HIV-2	✓
86703	Antibody; HIV-1 and HIV-2, single assay	✓
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)	✓
87081	Culture, bacterial, screening only, for single organisms	✓
87110	Culture, chlamydia	✓
87206	Smear, primary source, w/ interpretation; fluorescent &/or fast stain	✓
87207	Smear, primary source, w/ interpretation; special stain (e.g., malaria, herpes)	✓
88141	Cytopathology, cervical or vaginal (any reporting system) physician interp.	✓
88142	Cytopathology, cervical or vaginal (any reporting system) thin prep	✓
88143	Cytopathology, with manual screening and rescreening under physician supervision	✓
88147	Cytopathology smears, cervical or vaginal; screening in automated system	✓

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
88148	Cytopathology, screening by automated system with manual rescreening - phys. supervis.	✓
88150	Cytopathology, slides, cervical or vaginal; manual screening - phys. supervis.	✓
88155	Cytopathology, slides, cervical or vaginal; definitive hormonal evaluation	✓
88164	Cytopathology, slides, cervical or vaginal; (Bethesday System)	✓
88165	Cytopathology, with manual screening and rescreening – phys. supervis.	✓
88166	Cytopathology, with manual screening and computer-assisted rescreening – phys. supervis.	✓
88167	Cytopathology, with manual screening and computer-assisted rescreening - cell selection	✓
88302	Level II Surgical Pathology	✓
99201	New Patient - Office or other outpatient visit	✓
99202	New Patient - Office or other outpatient visit	✓
99203	New Patient - Office or other outpatient visit	✓
99204	New Patient - Office or other outpatient visit	✓
99205	New Patient - Office or other outpatient visit	✓
99211	Established Patient - Office or other outpatient visit	✓
99212	Established Patient - Office or other outpatient visit	✓
99213	Established Patient - Office or other outpatient visit	✓
99214	Established Patient - Office or other outpatient visit	✓
99215	Established Patient - Office or other outpatient visit	✓
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000	

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
	units	
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units	
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units	
J0560	Injection, penicillin G benzathine, up to 600,000 units	
J0570	Injection, penicillin G benzathine, up to 1,200,000 units	
J0580	Injection, penicillin G benzathine, up to 2,400,000 units	
J0690	Injection, cefazolin sodium, 500 mg	
J0694	Injection, cefoxitin sodium, 1 g	
J0696	Injection, ceftriaxone sodium, per 250 mg	
J0697	Injection, sterile cefuroximr sodium, per 750 mg	
J0698	Cefotaxime sodium, per g	
J0710	Injection, cephapirin sodium, up to 1 g	
J0715	Injection, ceftizoxime sodium, per 500 mg	
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	
J1850	Injection, kanamycin sulfate, up to 75 mg	
J1890	Injection, cephalothin sodium, up to 1 g	
J3000	Injection, streptomycin, up to 1 g	
J3260	Injection, tobramycin sulfate, up to 80 mg	
J3320	Injection, spectinomycin dihydrochloride, up to 2 g	
J3370	Injection, vancomycin HC1, 500 mg	
S0610	Annual GYN - new patient	✓
S0612	Annual GYN - established patient	✓
99395	Comprehensive Preventive Medicine Reevaluation	✓
00008257602	Alesse-28	

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
00555904358	Apri	
51285057628	Apri	
00555906658	Aranelle	
00555906667	Aranelle	
00555904558	Aviane	
51285001728	Aviane	
00555071558	Camila	
00062325002	Conceptrol	
00536999512	Condoms	
00555904958	Cryselle	
00052028306	Cyclessa	
00009074630	Depo-Provera	
00009737604	Depo-Provera	
00009470901	Depo-Subq Provera 104	
00052026106	Desogen	
11926022112	Encare	
50486022112	Encare	
00555904758	Enpresse	
00555034458	Errin	
00071092815	Estrostep FE	
00071092847	Estrostep FE	
00430057014	Estrostep FE	
02340012800	Extra Sensitive	
00062318012	Gynol II	
00062318501	Gynol II Extra Strength	
52544089228	Jolivette	
00555902557	Junel	
00555902742	Junel	
00555902757	Junel	
00555902658	Junel FE	
00555902858	Junel FE	
00555905058	Kariva	
00555906467	Kelnor 1/35	
08137008908	K-Y Plus	
00555901458	Lessina	
00555901467	Lessina	
52544027928	Levora-28	
70907001312	Lifestyles	

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
00008251402	Lo/Ovral -28	
51285007997	Loestrin	
00430053014	Loestrin 24 FE	
51285008370	Loestrin FE	
52544084728	Low-Ogestrel	
52544094928	Lutera	
00703680101	Medroxyprogesterone Acetate	
00703681121	Medroxyprogesterone Acetate	
59762453701	Medroxyprogesterone Acetate	
52544095021	Microgestin	
52544095121	Microgestin	
52544063028	Microgestin FE	
52544063128	Microgestin FE	
00052028106	Mircette	
51285011458	Mircette	
52544052628	Mononessa	
52544055028	Necon	
52544055228	Necon	
52544055428	Necon	
52544055628	Necon	
52544093628	Necon	
52544062928	Nora-Be	
51285009158	Nordette-28	
00555900858	Nortrel	
00555900867	Nortrel	
00555900942	Nortrel	
00555901058	Nortrel	
00555901258	Nortrel	
00052027301	Nuvaring	
52544084828	Ogestrel	
00062192001	Ortho-evra	
00062192015	Ortho-evra	
00062141116	Ortho Micronor	
00062190315	Ortho Tricyclen	
00062125115	Ortho Tricyclen LO	
00062190115	Ortho-Cyclen	
00062330400	Ortho-Diaphragm	
00062330500	Ortho-Diaphragm	

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
00062330600	Ortho-Diaphragm	
00062334500	Ortho-Diaphragm	
00062176115	Ortho-Novum	
00062178115	Ortho-Novum	
00430058014	Ovcon-35	
00430058114	Ovcon-35	
00430058214	Ovcon-35	
00430058514	Ovcon-50	
51285003893	Plan B	
64836000001	Plan B	
00555902058	Portia	
00093531628	Previfem	
00093531681	Previfem	
52544095428	Reclipsen	
51285005866	Seasonale	
66993061128	Solia	
00555901658	Sprintec	
50419043303	Tri-Levlen 28	
52544093528	Trinessa	
00008253601	Triphasil-28	
00093531528	Tri-Previfem	
00093531581	Tri-Previfem	
00555901858	Tri-Sprintec	
52544029128	Trivora-28	
22600064712	Trojan	
22600090750	Trojan	
22600090950	Trojan	
22600092050	Trojan	
22600093850	Trojan	
22600095000	Trojan	
22600095250	Trojan	
22600095850	Trojan	
22600097250	Trojan	
22600091750	Trogan Enz	
22600093050	Trogan Enz	
22600093150	Trogan Enz	
22600093250	Trogan Enz	
22600093270	Trogan Enz	

Code	Description	If checked, code is approved only in conjunction with V25 diagnosis or FP modifier
22600093350	Trogan Enz	
22600093750	Trogan Enz	
22600093770	Trogan Enz	
22600093950	Trogan Enz	
22600064212	Trojan Magnum	
22600064512	Trojan Magnum	
22600098050	Trojan Natural Lamb	
22600098750	Trojan Natural Lamb	
22600094550	Trojan Ribbed	
22600094750	Trojan Ribbed	
22600094950	Trojan Ribbed	
22600092240	Trojan Very Sensitive	
22600092340	Trojan Very Sensitive	
22600092640	Trojan Very Thin	
22600092740	Trojan Very Thin	
48723000111	VCF	
52925011201	VCF	
52925031214	VCF	
00555905158	Velivet	
00555905167	Velivet	
50419040203	Yasmin 28	
50419040503	Yaz	
52544038328	Zovia 1/50E	
52544038428	Zovia 1/50E	

Code	Description	If checked, code is only approved in conjunction with V25 diagnosis or FP modifier
58656	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
86780	Treponema pallidum	
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer assisted rescreening using cell selection and review under	
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	
88175	Cytopathology, cervical or vaginal (any reporting system) collect in preservative fluid, with screening by automated system, under physician supervision	
88365	Tissue in situ hybridization, interpretation and report	
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular, or jet injections); one vaccine (single or combination vaccine/toxoid)	
90706	Immunization, active; rubella virus vaccine, live	

ATTACHMENT G

FQHC AND RHC SERVICES

ATTACHMENT G

FQHC AND RHC SERVICES

CATEGORY OF SERVICE	COVERED SERVICES
Core Services as Defined in Section 1861 (Aa)(1)(A)-(C) of the Social Security Act	Physician services Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered) Pneumococcal vaccine and its administration and influenza vaccine and its administration Physician assistant services Nurse practitioner services Clinical psychologist services Clinical social work services Services and supplies incidental to clinical psychologist and clinical social worker services as would otherwise be covered if furnished by or incidental to physician services Part-time or intermittent nursing care and related medical supplies to a homebound individual (in the case of those FQHCs that are located in an area that has a shortage of home health agencies)

CATEGORY OF SERVICE	COVERED SERVICES
Additional FQHC Services	In addition to the above Core Services, FQHCs (as opposed to RHCs) are required to provide preventive primary health services under Sections 329, 330, and 340 of the Public Health Service Act and defined in Regulation 405.2448
Other Ambulatory Services	Any other Title XIX-payable ambulatory services offered by the Medicaid program that the FQHC undertakes to provide

ATTACHMENT H

SCHEDULE OF COPAYMENTS

ATTACHMENT H

SCHEDULE OF COPAYMENTS

EXTENDED FAMILY PLANNING
No premium charge (except 250 to 350 percent FPL group, which pays full premium and copayment below). Copayments apply to all Extended Family Planning enrollees irrespective of income.

SERVICE	COPAYMENT (Copayments are applied per person, per episode)
Health Care Provider Visits	$2
Thirty (30) Day Supply of Contraceptives	$1
Voluntary Sterilization Procedures	$15

STATE FUNDED PREGNANT WOMEN BETWEEN 250 AND 350 PERCENT OF THE FPL
Pay full monthly premium for age/sex appropriate rate range, and the following:

SERVICE	COPAYMENT (Copayments are applied per person, per episode)
Office Visits	$5
Ambulatory Surgical Procedures	$15
Prescriptions	$2
Inpatient Hospital Admission	$25
Non-Emergency Use of Emergency Transportation	$35

Note: State pays full SOBRA payment for this group

ATTACHMENT I

CONTRACTOR'S LOCATIONS

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472

Rhode Island Office
Tufts Health Plan
1 West Exchange Street, Suite 303
Providence RI 02903

ATTACHMENT J

CONTRACTORS' CAPITATION RATES SFY 2016

RIte Care
Proposed Capitation Rates
Rate Period 3/1/2017 - 6/30/2018
Including Reinventing Medicaid Program Initiatives

Capitation Rate Cell	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	Non-Profit Plans: 2% State Premium Tax: Non-Profit Plans	Non-Profit Plans: Proposed Capitation Rates: Non-Profit Plans	For-Profit Plans: 2% State Premium Tax: For-Profit Plans	For-Profit Plans: Est. ACA Issuer Fee: For-Profit Plans [2]	For-Profit Plans: Capitation Rates w/ Premium & Issuer Taxes
MF <1	$ 415.97	$ 40.47	$ 6.95	$ -	$ 9.46	**$ 472.85**	$ 9.73	$ 13.53	**$ 486.65**
MF 1-5	$ 132.11	$ 13.02	$ 2.21	$ -	$ 3.01	**$ 150.35**	$ 3.10	$ 4.30	**$ 154.74**
MF 6-14	$ 131.33	$ 12.64	$ 2.19	$ -	$ 2.98	**$ 149.14**	$ 3.07	$ 4.27	**$ 153.50**
Males 15-44	$ 180.91	$ 19.13	$ 3.05	$ 1.07	$ 4.17	**$ 208.33**	$ 4.29	$ 5.96	**$ 214.41**
Females 15-44	$ 270.92	$ 26.20	$ 4.52	$ 1.39	$ 6.18	**$ 309.21**	$ 6.36	$ 8.85	**$ 318.24**
MF 45+	$ 375.72	$ 38.79	$ 6.31	$ 1.66	$ 8.62	**$ 431.10**	$ 8.86	$ 12.33	**$ 443.69**
EFP	$ 8.88	$ 0.88	$ 0.15	$ -	$ 0.20	**$ 10.11**	$ 0.21	$ 0.29	**$ 10.41**
SOBRA (Pmt.)	$ 9,823	$ 968	$ 164	$ -	$ 224	**$ 11,179**	$ 230	$ 320	**$ 11,505**

[1] Risk Margin set at 1.5% of premiums before taxes
[2] ACA Issuer Fee, per estimate by the State based on UHC financial results, applicable to For-Profit plans only
[3] Includes Adult Immunizations

CSHCN and Substitute Care
Proposed Capitation Rates
Rate Period 3/1/2017 - 6/30/2018

Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [5]	Non-Profit Plans		For-Profit Plans		
					State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans [3]	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee For-Profit Plans [4]	Capitation Rates: For-Profit Plans
Adoption Subsidy	$ 492.61	$ 49.64	$ 8.26	$ 0.09	$ 11.23	$ 561.83	$ 11.56	$ 16.08	$ 578.24
Katie Beckett	$ 2,442.82	$ 236.59	$ 40.80	$ 0.08	$ 55.52	$ 2,775.81	$ 57.14	$ 79.42	$ 2,856.85
SSI < 15	$ 1,078.30	$ 109.48	$ 18.09	$ -	$ 24.61	$ 1,230.48	$ 25.32	$ 35.21	$ 1,266.40
SSI >= 15	$ 952.33	$ 92.79	$ 15.92	$ 0.80	$ 21.67	$ 1,083.51	$ 22.31	$ 31.00	$ 1,115.15
Substitute Care [3]	$ 657.65	$ 86.08	$ 11.33	$ 0.30	$ 15.41	$ 770.77	$ 15.86	$ 22.05	$ 793.27

[1] Risk Margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Premiums

[3] Substitute Care is only available under NHPRI, a Non-Profit Plan

Rhody Health Partners

Proposed Capitation Rates

Rate Period 3/1/2017 - 6/30/2018

RHP Population Cohort	Medical Component of Capitation Rates	Admin Component of Capitation Rates	Risk Margin [1]	Assess-ments [3]	State Premium Tax [2]: Non-Profit Plans	Capitation Rates: Non-Profit Plans	State Premium Tax [2]: For-Profit Plans	ACA Issuer Fee: For-Profit Plans [4]	Capitation Rates: For-Profit Plans
ID	$ 1,001.59	$ 77.98	$ 16.44	$ 1.66	$ 22.40	$ 1,120.07	$ 23.05	$ 32.05	$ 1,152.77
SPMI	$ 2,067.63	$ 181.26	$ 34.25	$ 1.66	$ 46.63	$ 2,331.43	$ 47.99	$ 66.71	$ 2,399.50
Other Disabled 21-44	$ 816.45	$ 70.34	$ 13.50	$ 1.66	$ 18.41	$ 920.36	$ 18.95	$ 26.33	$ 947.23
Other Disabled 45+	$ 1,169.78	$ 102.01	$ 19.37	$ 1.66	$ 26.38	$ 1,319.20	$ 27.16	$ 37.74	$ 1,357.72

[1] Risk margin set at 1.5% of premium before taxes

[2] State Premium Tax is set at 2% of Premiums

[3] Includes Adult Immunization

[4] ACA Issuer Fee, per estimate by the State based on UHC financial results, applicable to For-Profit plans only

Medicaid Expansion

Rate Period 3/1/2017 - 6/30/2018

Including Implementation of Reinventing Medicaid Program Initiatives

Based on Emerging Experience and Trends

Rate Cell		Revised A/G Factors [1]	Rate Period Forecast Enrollment	Normalized A/G Factor [1]	Non-Profit Plans: Medical [3]	Admin + Risk Margin	Assess-ments [2]	State Prem. Tax	Non-Profit Capitation Rates	For-Profit Plans: Medical [3]	Admin + Risk	Assess-ments [2]	State Prem. Tax	Est. ACA Issuer Tax	For-Profit Capitation Rates
RHE F 19-24	ME01	0.6176	6,530	**0.6178**	$ 272.81	$ 28.91	$ 1.66	$ 6.17	$ 309.55	$ 272.81	$ 28.91	$ 1.66	$ 6.35	$ 8.83	$ 318.56
RHE F 25-29	ME02	0.7554	3,902	**0.7556**	$ 332.90	$ 35.36	$ 1.66	$ 7.55	$ 377.47	$ 332.90	$ 35.36	$ 1.66	$ 7.77	$ 10.80	$ 388.49
RHE F 30-39	ME03	1.1271	3,317	**1.1274**	$ 497.00	$ 52.76	$ 1.66	$ 11.26	$ 562.69	$ 497.00	$ 52.76	$ 1.66	$ 11.59	$ 16.11	$ 579.12
RHE F 40-49	ME04	1.3091	4,250	**1.3094**	$ 577.36	$ 61.28	$ 1.66	$ 13.08	$ 653.39	$ 577.36	$ 61.28	$ 1.66	$ 13.46	$ 18.71	$ 672.48
RHE F 50-64	ME05	1.3471	10,280	**1.3474**	$ 594.12	$ 63.06	$ 1.66	$ 13.46	$ 672.30	$ 594.12	$ 63.06	$ 1.66	$ 13.85	$ 19.25	$ 691.95
RHE M 19-24	ME06	0.4070	7,103	**0.4071**	$ 179.73	$ 19.05	$ 1.66	$ 4.07	$ 204.51	$ 179.73	$ 19.05	$ 1.66	$ 4.19	$ 5.82	$ 210.45
RHE M 25-29	ME07	0.6452	5,888	**0.6453**	$ 284.23	$ 30.20	$ 1.66	$ 6.45	$ 322.54	$ 284.23	$ 30.20	$ 1.66	$ 6.63	$ 9.22	$ 331.95
RHE M 30-39	ME08	0.8312	7,365	**0.8314**	$ 366.37	$ 38.91	$ 1.66	$ 8.31	$ 415.24	$ 366.37	$ 38.91	$ 1.66	$ 8.55	$ 11.88	$ 427.36
RHE M 40-49	ME09	1.2081	5,854	**1.2084**	$ 532.76	$ 56.55	$ 1.66	$ 12.07	$ 603.05	$ 532.76	$ 56.55	$ 1.66	$ 12.42	$ 17.27	$ 620.67
RHE M 50-64	ME10	1.5131	8,690	**1.5134**	$ 667.41	$ 70.83	$ 1.66	$ 15.12	$ 755.02	$ 667.41	$ 70.83	$ 1.66	$ 15.56	$ 21.63	$ 777.08
Composite		0.9998	63,179	**1.0000**	$ 440.93	$ 46.80	$ 1.66	$ 9.99	$ 499.38	$ 440.93	$ 46.80	$ 1.66	$ 10.28	$ 14.29	$ 513.96

[1] A/G factors reflect the implied A/G factors from 7/1/2015 - 6/30/2016 experience, normalized to achieve a risk factor of 1.0 with the enrollment forecast

[2] Includes Adult Immunizations

[3] Includes Pediatric Rate increase in applicable rate cells only (ME01 & ME06)

ATTACHMENT K

CONTRACTOR'S INSURANCE CERTIFICATES

ATTACHMENT L

RATE-SETTING PROCESS

Attachment L - Rate Setting Process

Please see the attached Rate Books:

RIte Care Data Book
Rates for the period 3/1/2017 through 6/30/2018

Children with Special Health Care Needs (CSHCN) and Substitute Care Data Book
Rates for the period 3/1/2017 through 6/30/2018

Rhody Health Partners Data Book
Rates for the period 3/1/2017 through 6/30/2018

Medicaid Expansion Data Book
Rates for the period 3/1/2017 through 6/30/2018

ATTACHMENT M

PERFORMANCE GOALS

ATTACHMENT M

PERFORMANCE GOALS

The overarching goal of the Performance Goal Program is to support EOHHS's Comprehensive Quality Strategy of providing eligible Medicaid beneficiaries with services that are accessible, of high quality, and promote positive health outcomes in a cost efficient and effective manner. EOHHS will include in its Performance Goal Program, the performance measures, if not already included herein, from the final core and menu set of quality measures adopted by the State Innovation Model (SIM) Quality Measure Harmonization workgroup.

The table of performance measures included in this attachment shall be considered a menu set of measures that EOHHS can utilize for its annual Performance Goal Program. Measures not selected for the annual performance goal program will still be included in the Health Plan's annual submission as monitoring measures. Monitoring measures are reported, but not incentivized. EOHHS reserves the right to make appropriate modifications and adjustments each year to the program based on the Health Plan's previous performance as well as current EOHHS aims and objectives.

The performance goal measures will focus on the following key quality domains: access to preventative care, behavioral health, clinical quality, and utilization, specifically high utilizers. The measure will also align to the extent possible with national measure sets and reports such as the CMS Adult and Child Core Set of Quality Measures.

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
Utilization	ED Emergency Room Utilization Rate per 1000	TBD based on baseline performance from CY 2015	Encounter Data
	Re-hospitalization within 30 days of discharge from inpatient psychiatric care (stratify by children <18 years and adults > 18 years).	TBD based on baseline performance from CY 2015	Encounter Data
Access to Care	Adult members had an ambulatory or preventive care visit.	Medicaid Quality Compass® 95th percentile	HEDIS®
	Child members had an ambulatory or preventive care visit.	Medicaid Quality Compass® 95th percentile	HEDIS®

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	Child members had well-child visits in their first 15 months of life	Medicaid Quality Compass® 95th percentile	HEDIS®
	Child members had well-child visits in their 3rd through 6th years of life	Medicaid Quality Compass® 95th percentile	HEDIS®
	members were satisfied with access to urgent care	Medicaid Quality Compass® 95th percentile	CAHPS®
	Percentage of new members who are able to obtain an appointment with their PCP and/or specialists inclusive of behavioral health within the contractual time frames*	Medicaid Quality Compass® 95th percentile	Annual Provider Access Secret Shopper Study
Medical 3Home/Preventive Care	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday	Medicaid Quality Compass® 95th percentile	HEDIS®

*EOHHS reserve the right to modify this metric based on the availability and frequency of the Annual Provider Access Study conducted by RI Medicaid External Quality Review Organization.

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps, and rubella (MMR); two H influenza type B (HiB); three Hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Medicaid Quality Compass® 95th percentile	HEDIS®
	The percentage of female adolescents 13 years of age who had three dosages of the HPV vaccine by their 13th birthday.	Medicaid Quality Compass® 95th percentile (Baseline)	HEDIS®
	Child members had a visit with a Health Plan PCP (HEDIS Access): • 12 – 24 Months • 25 Months – 6 Years • 7 – 11 Years • 12 – 19 Years	Medicaid Quality Compass® 95th percentile	HEDIS®
	Children received at least one age appropriate blood lead screen prior to their second birthday.	Medicaid Quality Compass® 95th percentile	HEDIS®
	Members 18 years of age	CAHPS®	HEDIS®
	and older received advice to quit smoking	Medicaid Quality Compass® 90th percentile	

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	Adult BMI Assessment (ABA): The percentage of members 18 – 74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year. age and older received advice to quit smoking	Medicaid Quality Compass® 90th percentile Medicaid Quality Compass® 90th percentile	HEDIS®
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): The percentage of members 2 – 17 years of age	Medicaid Quality Compass® 90th percentile Medicaid Quality Compass® 90th percentile	HEDIS®HEDIS®
	Adult BMI Assessment (ABA): The percentage of members 18 – 74 years of age who had an outpatient visit and who had their body mass index (BMI)	Medicaid Quality Compass® 90th percentile	HEDIS®
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): The percentage of members 2 – 17 years of age	Medicaid Quality Compass® 90th percentile	HEDIS®
	Who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year?		

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	Frequency of On-going Prenatal Care (FPC): The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: >/= 81 percent of expected visits.	Medicaid Quality Compass® 95th percentile	HEDIS®
	Members received timely prenatal care and timely postpartum care	Medicaid Quality Compass® 95th percentile	HEDIS®
	Adolescent Well-Care Visits (AWC): The percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Medicaid Quality Compass® 95th percentile	HEDIS®
Overuse/Appropriateness	Use of Imaging Studies for Low Back Pain (LBP): The percentage of members with a primary diagnosis of	Medicaid Quality Compass® 90th percentile	HEDIS®
	low back pain who **DID NOT** have an imaging study (plain X-Ray, MRI, CT		
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: % of 1- 17 years of age on two or more antipsychotics	Medicaid Quality Compass® 90th percentile (Baseline)	HEDIS®
Women's Health	Women enrolled 18 – 64 years received cervical cancer screening.	Medicaid Quality Compass® 95th percentile	HEDIS®

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	The percentage of women 15 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	Medicaid Quality Compass® 95th percentile	HEDIS®
Chronic Care	Comprehensive Diabetes Care (CDC): The percentage of members 18-75 years of age with diabetes (type 1 and 2) who had Hb1Ac testing, Hb1Ac poor control (>9.0%), Hb1Ac control (<8.0%), Eye Exam (retinal) performed, and BP Control (<140/90mm Hg).	Medicaid Quality Compass® 90th percentile	HEDIS®
	Controlling High Blood Pressure (CBP): The percentage of members 18 – 85 years	Medicaid Quality Compass® 90th percentile	HEDIS®
	Of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90) during the measurement year.		
	Members 5-64 years of age during the measurement who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period (75% rate component)	Medicaid Quality Compass® 90th percentile	HEDIS®

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	Pharmacotherapy Management of COPD Exacerbation (PCE): The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 – November 30 of the measurement year and who were dispensed appropriate medications.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV who had a HIV viral load <200 copies/mL at last HIV viral load test during the measurement year	90%	Health Resources and Services Administration
Behavioral Health	The percentage of discharges for	Medicaid Quality	HEDIS®
	members six years of age or older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner: o Follow-up within thirty (30) days of discharge Follow-up within seven (7) days of discharge	Compass® 95th percentile	

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
	Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (Effective Acute Phase Treatment).	Medicaid Quality Compass® 90th percentile	HEDIS®
	Follow-up Care for Children Prescribed ADHD Medication (ADD): The percentage of members 6 – 12 years of age as of the Index Prescription Start Date	Medicaid Quality Compass® 95th percentile	HEDIS®
	with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.		
	Initiation and Engagement of Alcohol and Other Drug Dependence: Initiation of Treatment w/in 14 days and Engagement of Treatment w/in 30 days	Medicaid Quality Compass® 90th percentile	HEDIS®
	Adherence to Antipsychotic Medications for individuals with Schizophrenia: % of members 19-64 dispensed and remained on med for 80% of treatment	Medicaid Quality Compass® 90th percentile	HEDIS®

PERFORMANCE MEASURES			
AREA	**GOAL**	**BENCHMARK**	**SOURCE OF MEASURE**
Compliance	The percentage of calls received by the organization's member services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.	Medicaid Quality Compass® 90th percentile	HEDIS® (Baseline)
	Accurate submission of encounter data	99% Full Award 95% Partial Award	Health Plan
Total Cost of Care	Decrease in the average total cost of care of high utilizer population	• 50th percentile benchmark =	Encounter Data
	year over year (CY 2014/CY 2015)[1]	0-50% of inflation factor • 75th percentile benchmark = 0-2.5% □ 100% = >2.5% decrease in PMPM	
Alternative Payment Methodologies	Increase the percentage of Medicaid payments shall be made through an Alternative Payment Methodology as defined in the contract	85%	Health Plan

ATTACHMENT N

SPECIAL TERMS & CONDITIONS

ATTACHMENT N

SPECIAL TERMS & CONDITIONS

1. Definitions

(1) **Actuarial Certification:** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs under the terms of the contract. The capitation rates have been developed in accordance with generally accepted actuarial principles and practices and meets the standards described in 42 CFR 438.5 which is dedicated to rate development standards.

(2) **Attribution**: Attribution is the process for defining the population of members who have been specifically defined as receiving primary services through a provider affiliated with an EOHHS certified Accountable Entity that has a total cost of care based sub-contractual arrangement between Contractor and the Entity.

The Attribution methodology for the Accountable Entity Coordinated Care Pilot Program is as follows:

Assignment hierarchy:

- First – Integrated Health Home (IHH) Assignment. If a member is assigned to an IHH and that IHH is separately certified as a Type 2 AE, or the IHH is a participating provider in a certified "comprehensive" or Type 1 AE then the member is attributed to the applicable AE. The IHH assignment is based on the BHDDH file provided to Contractor.
- Second – PCP Assignment. Member is attributed to the PCP of record with Contractor. This will be based upon (a) the PCP to whom they are assigned upon enrollment or (b) the PCP to whom they are assigned based on a request from the member to change his/her PCP assignment.

The Attribution methodology for the Comprehensive Accountable is set forth in the Attribution Guidance included as an attachment to *"RI EOHHS, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners"*

(3) **Baseline Medical**: Baseline Medical means one hundred percent (100%) of the medical portion of the rate for each Premium Rating Group as identified in ATTACHMENT J plus any separate SOBRA payments for maternity-related services, if applicable. Baseline Medical includes any amounts that may be withheld pursuant to Section 2.15.01.1 (Offsets to Capitation in Relation to Implementation of Alternative Payment Methodologies) of this Agreement. Baseline Medical shall be calculated as the full amount contractor would have received had there not been any offsets to

capitation. For the purpose of Risk Share/Gain Share calculation set forth in Section 2 of this Attachment "Risk Sharing/Gain Sharing Methodology," the Baseline Medical shall exclude any amount of the medical portion of the rate that is subject to a separate Risk Share/Gain Share arrangement as set forth in Section 12 of this Attachment "Separate Risk-Share/Gain-Share Provision for Treatment of Enrollees in Integrated Health Homes at Specified Community Mental Health Centers."

Baseline shall exclude any payments made to Contractor pursuant to Section 2.15.01.03 (Incentive Payments) of this contract and 2.08.02 (Health System Transformation Project) of this contract.

(4) **Contract Period:** Contract Period #1 means the period from March 1, 2017 to June 30, 2018. Contract Period #2 is for the period from July 1, 2018 through June 30, 2019. Subsequently, the Contract Period means each 12-month period beginning July 1, and ending June 30, of the next year.

(5) **Gain Share:** Gain Share means the terms by which EOHHS and the Contractor share in the gain realized from participating in the program for a Contract Period.

(6) **Incentive Payments:** Incentive arrangement means any payment mechanism under which a MCO, may receive additional funds over and above the capitation rates. Incentive payments are payments designed to support program initiatives tied to meaningful quality goals and performance measure outcomes. Contractor's receipt of incentive payments is based solely on satisfactory performance and is not conditional on Contractor's compliance with an Inter-governmental agreement.

(7) **Medical Expenses**: Medical Expenses means those benefits and services that the Contractor is obligated to provide or pay for pursuant to Attachments A, B and O, including but not limited to preventive services, laboratory, diagnostic and radiology services, inpatient and outpatient hospital services, physician services, mental health and substance abuse services, long-term services and supports, prescription drugs, family planning services, behavioral health, emergency and palliative services, oral surgery, general anesthesia, interpreter/translation services, and behavior management.

Medical expenses shall not include payments made pursuant to Section 2.15.01.03 (Incentive Payments) and Section 2.08.02 (Contracting with EOHHS Certified Accountable Entities, inclusive of Sections 2.08.02.01 through 2.08.02.06) of this contract.

- Medical Expenses and Shared Savings Arrangements with AEs

Medical expenses shall also include (a) payments made to Accountable Entities and (b) savings retained by Contractor pursuant to shared savings arrangements based on EOHHS-compliant Total Cost of Care agreements and calculations. This applies if the target Total Cost of Care (TCOC) exceeds the actual TCOC for the attributed AE members. For example, if the targeted TCOC is $100 and actual AE TCOC expenses are $90, there is a savings of $10. If

$5 goes to the AE and $5 is retained by Contractor, Medical Expenses shall include (a) the $5 to the AE and (b) the $5 retained by the MCO.

- Medical Expenses and Shared Risk Arrangements with AEs

In the event of shared risk arrangements with AEs, Medical expenses shall exclude any costs that the AE is obligated for under the terms of that arrangement. For example, in a 50/50 shared risk arrangement if the targeted TCOC is $100 and actual TCOC expenses are $110 there is a shared risk of $10. If $5 of that shared risk goes to the AE, Medical Expenses shall be reduced by the $5 in losses expenses retained by the AE and by the $5 in losses retained by the MCO.

Note that Total Cost of Care calculations must be compliant with the TCOC requirements as set forth in "RI EOHHS, *Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*" including risk adjustment in reference to the base population served by the Accountable Entity. Total cost of care calculations must also include an EOHHS compliant quality score factor that is used as a multiplication (the quality multiplier must be between 1.0 and 0.00) factor in shared savings calculations to help ensure that any shared savings that are realized are due to observed quality of care and outcomes rather than denial of care (e.g. a quality score of 75% applied to a shared savings pool of $100 = maximum pool of $75). In the event of shared risk arrangements, any risk borne by the Accountable Entity shall not be included in Medical Expenses.

Medical expenses must be reduced by any recoveries from other payers including those pursuant to coordination of benefits, third party liability, reinsurance, stop-loss arrangements, rebates, or adjustments in claims paid or from providers, including adjustments to claims paid.

For the purpose of Risk Share/Gain Share calculation set forth in Section 2 of this Attachment "Risk Sharing/Gain Sharing Methodology," for Contract Period 1 adjustments are made to the calculation to recognize the separate Risk Share/Gain Share arrangement as set forth in Section 12 of this Attachment "Separate Risk-Share/Gain-Share Provision for Treatment of Enrollees in Integrated Health Homes at Specified Community Mental Health Centers." With respect to Medical Expenses, the calculation of Medical Expenses shall exclude an amount equal to the revenue included in the medical portion of the rate that is associated with the behavioral healthcare services specified in the *IHH Provisions*

(8) Medical Portion of the Rate: The Medical Portion of the Rate is as shown in Attachment J.

(9) **Penalty:** A penalty is an amount of the capitation payment that is withheld unless contractor satisfies an operational requirement under the contract and is not subject to the requirements of Section 438.69 (b (3).

(10) **PMPM**: PMPM means Per Member Per Month.

(11) **Premium Rate**: For any given period, Premium Rate means the higher amount of (a) the capitation payments made PMPM by EOHHS to the Contractor for members for each Premium Rating Group enrolled during that period, or (b) the capitation payments that would have been made had there been no offsets to capitation pursuant to the provisions of Section 2.15.01.1 of this Agreement. Premium rate includes a medical and administrative portion.

(12) **Premium Rating Group**: Those groups, as defined in Attachment J, for which the EOHHS issues a capitation payment to the Contractor on a PMPM basis.

(13) **Quarter:** Quarter means a calendar quarter (e.g. January 1 through March 31, April 1, through June 30, July 1 through September 30, and October 1 through December 31).

(14) **Risk Corridor:** Risk corridor is a risk sharing mechanism that accounts for both profits and losses between the State and Contractor.

(15) **Risk Share:** Risk Share means the terms by which EOHHS and the Contractor share in the loss realized from participating in the program for the duration of a Contract Period.

(16) **Reinsurance:** Contractor will reinsure Medical Expenses for Members. Such costs will be a component of Medical Expense that will be reduced by any claims against reinsurance.

(17) **Withhold Arrangement:** A withhold arrangement is a method by which the State may institute financial rewards for Contractor for meeting performance targets, specified in the contract, that are designed to drive managed care plan performance in ways distinct from the general operational requirements under the contract.

(18) **Withhold Arrangement with an AE in a Shared Risk Arrangement:** In the event of a shared risk arrangement with an AE, or any other entity in a shared risk arrangement it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this, upon entering into such agreement Contractor shall set forth a clear arrangement (e.g. a withhold or escrowed funds) to ensure that funds are available for financial settlement in the event that medical expenses exceed the total cost of care projection for the performance period.

2. Risk Share/Gain Share Methodology

Risk share/gain share is based on the Contract Period and is based on the cumulative experience for all Premium Rating Groups within the product line (e.g. Rhody Health Partners).

The actual cumulative Medical Expenses for the Contract Period and in aggregate for all premium rating groups within a product line for the Contract Year will be reported to EOHHS each month based on Medical Expenses for claims paid for services provided on dates of service during the Contract Period.

Risk share/gain share is calculated as Baseline Medical minus actual cumulative Medical Expenses.

If actual cumulative Medical Expenses are greater than Baseline Medical, Risk Share provisions as shown below apply.

Risk Share

1. If the actual cumulative Medical Expenses are between 100% of the Baseline and 101.5% of the Baseline, Contractor shall bear 100% of those expenses.
2. If the actual cumulative Medical Expenses are between 101.5% of the Baseline and 105% of the Baseline, Contractor shall bear 40% of that expense and EOHHS shall bear 60% of that expense.
3. If the actual cumulative Medical Expenses are greater than 105% of the Baseline, Contractor shall bear 10% of that expense and EOHHS shall bear 90% of that expense.

If actual cumulative Medical Expenses are less than Baseline Medical, the Gain Share provisions apply.

Gain Share

1. If the actual cumulative Medical Expenses are between 98.5% of the Baseline and 100% of the Baseline, Contractor shall retain 100% of those gains.

2. If the actual cumulative Medical Expenses are between 98.5% of the Baseline and 95% of the Baseline, Contractor shall retain 40% of those gains and EOHHS' share will be 60%.

3. If the actual cumulative Medical Expenses are less than 95% of the Baseline, Contractor shall retain 10% of those gains and EOHHS' share shall be 90%.

   These risk share and gain share arrangements are summarized in **Table 1** below.

   All contracts for services and the terms of those contracts, including and not limited to payment arrangements and shared savings/risk reconciliations with all providers

and Accountable Entities that serve Medicaid enrollees must be available for review by EOHHS or its agents. Contracts with medical providers that are not made available will be subject to exclusion from the Risk-Share/Gain Share arrangement.

The Contractor shall require that their external auditor, in the Annual Report of Independent Auditors or in a separate letter to Management and EOHHS, specifically address their review and testing of the Contractor's Risk Share/Gain Share financial reports and the related Contractor's Receivable and/or Payable to/from EOHHS as of December 31 of each year.

In addition, the Independent Auditors will review and test the annual final AE TCOC performance statements and the related shared savings or shared risk payable to/from the AE and address results in the same manner as described above.

a. Table 1. Risk and Gain Share Arrangement

Risk Sharing Provisions	**Plan Share of Expenses**	**EOHHS Share of Expenses**
For Medical Expenses between 100% and 101.5% of Baseline	100%	0%
For Medical Expenses between 101.5% and 105% of Baseline	40%	60%
For Medical Expenses greater than 105% of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gains**	**EOHHS Share of Gains**
For Medical Expenses between 98.5% and 100% of Baseline	100%	0%
For Medical Expenses between 95% and 98.5% of Baseline	40%	60%
For Medical expenses less than 95% of Baseline	10%	90%

b. Exclusions for purposes of the Risk-Share and Gain Share Calculations.

Risk/Gain share calculations are based on cumulative medical expenses. Calculations of medical expenses shall not include:

- Provider incentive arrangements that were not approved by EOHHS.
- Provider incentives that exceed EOHHS approved levels.
- Expenditures for the administrative portion of payments made to subcontractors or through intercompany arrangements for the purpose of administration and/or payment of covered services including arrangements for Durable Medical Equipment (DME), pharmacy, and behavioral health.

- Expenditures for non-medical benefits made through intercompany arrangements which are not paid directly to the providers including arrangements for Durable Medical Equipment, pharmacy, and behavioral health.

- In accordance with Section 1927(a)(7) of the Affordable Care Act (ACA), 837 Encounter data submissions for all professional and institutional claims will be subject to editing that will validate the accuracy for the J-Code/NDC combination for physician administered drug claims, institutional, or outpatient claims. Claims submitted with missing NDCs or invalid J-Code/NDC combinations will not be accepted as a complete claim and will be excluded from calculations of medical expenses.

c. Offsets for the purposes of the Risk-Share/Gain Share calculations include:

- All TPL collections by Contractor, including those pursuant to subrogation.

- Reinsurance payments made to the Contractor

- Drug Rebates received or receivable for drugs provided to members during the contract.

- EOHHS reserves the right to alter the process for subrogation collections at a future date.

- All Stop Loss Claims.

- Any claims subject to a separate Risk-Share/Gain-Share calculation

3. Reconciliation and Payment

The cumulative Risk Share/Gain Share Report for the Contract Period shall be submitted each month on a form set forth by EOHHS, including attestation as to the accuracy and completeness of the Report. In the event that the reported medical expenses exceed or are less than the Medical Expenses Threshold, the signed Risk Share/Gain Share Report shall serve as the risk/gain-sharing request for payment to or recoupment from the Contractor. A separate report shall be completed by the Contractor for each population covered by the Contractor.

Any Medical Expenses that are subject to the separate Risk Share/Gain Share arrangement as set forth in Section 12 of this Attachment "Separate Risk-Share/Gain-Share Provision for Treatment of Enrollees in Integrated Health Homes at Specified Community Mental Health Centers" shall be separately identified.

EOHHS shall review the Risk Share/Gain Share Report submissions on a routine and periodic basis and the parties mutually shall seek to resolve any questions concerning the amount of the risk/gain-sharing request for payment or recoupment. The risk/gain sharing payment or recoupment shall be made within 90 days of resolution in accordance with the next routine payment cycle after the receipt and reconciliation of the Contractor's Risk Share/Gain Share Report. Final settlement is based on review of the complete experience for the contract period following the full 12-month run out as set forth below. When EOHHS requests Contractor to perform a reconciliation of encounter data, Contractor agrees to submit the reconciliation to EOHHS within fifteen (15) business days. In the event Contractor's response takes longer to be submitted, EOHHS may at its discretion move forward to final settlement without regard to any additional medical expenses that might have been identified.

- The cumulative Risk Share/Gain Share Report will include no allowance for incurred but not reported (IBNR) claims. Risk/gain sharing will be based only on claims paid experience. To assure fairness in resolving outstanding claims, EOHHS will allow inclusion of claims for services provided to eligible and enrolled members for a period not to exceed 365 days from the date of a Covered Service. In its request for payment to EOHHS, the Contractor will separately identify claims with dates of service from prior periods to assure accurate calculation of the Risk-Share/Gain Share payment or recoupment. This procedure will assure that no Risk Share/Gain Share period goes back to a date earlier than 365 days from the date of service.

- This Agreement provides Risk Share/Gain Share for claims paid for Covered Services for eligible and enrolled members with dates of service during the applicable Contract Period.

- If, six (6) months after the start of a Risk Share/ Gain Share contract period, the Contractor's Risk Share/ Gain Share Report indicates that medical expenses have either exceeded the medical portion of the capitation dollars paid to the Contractor or are less than the medical portion of the capitation dollars paid to the Contractor by at least 30% or more, EOHHS may make partial settlement payments or recoupments on an interim basis prior to the end of the contract period and/or the final settlement period. Related risk share payments shall be based on cash expenditures as shown in the Risk Share/Gain Share Report. Related gain share recoupments shall be based on Risk Share/Gain Share reports that are inclusive of IBNR. EOHHS will provide the Contractor with the payment or recoupment dollar amount not less than 45 calendar days in advance of the actual date of the payment or recoupment.

ADDITIONAL SPECIAL TERMS AND CONDITONS

4. Performance Requirements

The success of this Agreement depends on the parties' shared commitment to work toward achievement of goals designed to improve health and functional status of enrollees. To achieve these goals, Contractor agrees to implement certain activities to improve access to primary health services and community-based long-term services and supports where appropriate, to improve appropriate use of the emergency room, and to implement specific person-centered care management programs for populations that are frequent users of services. Such programs will be developed by Contractor in consultation with staff of EOHHS or EOHHS' designees and will be subject to approval by EOHHS. It is agreed that such goals and programs will be reviewed at least annually and that a report will be submitted by Contractor to EOHHS and the board of directors of Contractor describing the programs and the outcomes of the programs.

In accordance with requirements as issued by the US Office of Inspector General (OIG) and other authorities, the contractor shall collaborate with EOHHS and/or its designee(s) to develop specific audit procedures to ensure the Contractor's reported medical expenses, as detailed in risk share, stop loss, financial statements and other submissions, are accurate and compliant with medical expenses as defined in the Agreement.

5. Reports

It is a requirement of this Agreement that Contractor submit monthly, quarterly, or annual reports to EOHHS in a form and format approved by EOHHS. These reports are due to EOHHS based on the timeframes indicated on the reporting calendar in Attachment Q. If reports are not submitted by the Contractor within the specified timeframe, EOHHS may impose sanctions as defined in additional required reports include, but are not limited to:

- Total expenditures on all claims and non-claim related activities, premium revenue, the calculated medical loss ratio (MLR) and any remittances owed must be submitted within 90 days from the close of the fiscal year per 42 CFR 438.8(c)
- If the minimum MLR standard is required by EOHHS, Contractor must provide a remittance for any reporting year for which Contractor does not meet the minimum standard. Contractor is required to submit reports for each MLR reporting year. Reports must include the enumerated list of items with 12 months of the end of the year.

EOHHS agrees that all reports and discussions will be maintained confidentially and provided to other parties only as required by state or federal law or regulation.

6. SOBRA Reporting

For the purpose of reporting medical expenses, SOBRA related expenses are to be reported using the following CPT codes (treatment) and ICD-10 codes (diagnosis):

59400 ≤ CPTx ≤ 59430 59500 ≤ CPTx ≤ 59530	**Any Procedure Code**

640xx ≤ Dx1 ≤ 679.99 V22xx ≤ Dx1 ≤ V23.99 V26xx ≤ Dx1 ≤ V26.99	**Primary Diagnosis**
V24xx ≤ Dxx ≤ V24.99	**Any Diagnosis**

EOHHS agrees that all reports and discussions will be maintained confidentially and provided to other parties only as required by state or federal law or regulation

7. Operational Reports

Contractor agrees to maintain during the term of this Agreement detailed records allocating Medical Expenses, by each Premium Rating Group. EOHHS may conduct or direct the Contractor to conduct periodic reviews of such records.

8. Payments to Certified Patient Centered Medical Homes

For all enrolled adult and pediatric members whose medical home is (a) certified as a Patient Centered Medical Home or (b) a participating practice in the Rhode Island Care Transformation Collaborative (CTC), Contractor shall pay the negotiated per member per month rate.

9. State Right to Open Up Participation

The State reserves the right, after contract award, to open up participation, without competition, to other health plans, including ones meeting the definition of a Medicaid managed care organization under Section 4701 of the Balanced Budget Act of 1997.

10. Reports on Subcontracts with Accountable Entities.

Contractor shall provide regular reports in a format and on a schedule agreed upon with EOHHS on the status on its subcontracts with Accountable Entity Coordinated Care arrangements. These shall include: (a) identification of executed subcontracts, or status of subcontract development; (b) strategies for improved care coordination and improved outcomes (c) identification of delegated functions and plan for, or status of, oversight and monitoring; (d) identification of the basis of attribution and the number and characteristics of attributed members; (e) access, utilization, quality and outcome metrics; (f) the basis for the total cost of care calculation along with current and projected experience; (g) emerging issues and/or concerns.

11. Stop-Loss Claiming for Pharmacy Expenditure in the Treatment of Enrollees with Hepatitis C

Pharmacy expenditures for treatment of Enrollees with Hepatitis C are subject to EOHHS-established stop-loss provisions as set forth in the Rhode Island Executive Office of Health and Human Services document entitled *Provisions for Stop Loss Claiming for Pharmacy Expenditure Treatment of Enrollees with Hepatitis C (Hepatitis C Provisions).* Contractor may submit a stop-

loss claim to EOHHS for enrollees with Hepatitis C when the actual average PMPM expenditure for pharmacy treatment exceeds the threshold PMPM as set forth in the *Hepatitis C Provisions.* To qualify for stop loss claiming, Contractor must comply with EOHHS-established clinical guidelines when authorizing a prescription for FDA approved Hepatitis C medications. One hundred percent (100%) of the Contractor's actual costs in excess of the PMPM threshold level as set forth in the *Hepatitis C Provisions* will be reimbursed by EOHHS to the Contractor. Exclusion of Pharmacy Expenditures for Persons with Hepatitis C that are associated with other stop loss claiming pursuant to this Agreement is required. This exclusion does not relate to transplants. Transplants are addressed specifically in Section 1.55 (Stop-Loss). Contractor shall ensure that in the event of a transplant, pharmacy expenditures for persons with Hepatitis C are not claimed in more than one stop loss claim."

12. Separate Risk-Share/Gain-Share Provision for Treatment of Enrollees in Integrated Health Homes at Specified Community Mental Health Centers

Certain specified behavioral healthcare expenditures incurred during Contract Period #1 (ending June 30, 2018) and Contract Period #2 (ending June 30, 2019) and for the treatment of Enrollees assigned to an Integrated Health Home at a Community Mental Health Center are subject to a separate risk share/gain share provision as set forth in the Rhode Island Executive Office of Health and Human Services document entitled *Provisions for Separate Risk Share/Gain Share Claiming for Specified Behavioral Healthcare Expenditures for the Treatment of Enrollees in an Integrated Health Home (IHH)*, dated February 20, 2017.

For purposes of the Risk Share/Gain Share methodology outlined in Section 2 of this Attachment, "Risk Sharing/Gain Sharing Methodology," the Contractor shall exclude:

- From its Baseline Revenue, any revenue included in the medical portion of the rate that is associated with the behavioral healthcare services specified in the *IHH Provisions*

- From their Cumulative Medical Expenses, an amount equal to the revenue included in the medical portion of the rate that is associated with the behavioral healthcare services specified in the *IHH Provisions* on behalf of Enrollees concurrently in an Integrated Health Home

13. Re-Inventing Medicaid Initiatives

In support of the EOHHS's Re-Inventing Medicaid Initiative, the Contractor will undertake and/or participate in strategies aimed at improving coordination of care and lowering total cost of care. These include the Patient Center Medical Home program for children and adults including the Community Health Team program; initiatives with particular focus on high utilizers (defined by EOHHS and/or the Contractor), such as the Communities of Care program and Integrated Health Home program; the Provider/Physician Incentive initiative program; participating in the RNP program; and targeting savings by increasing the portion of laboratory services provided at the lowest costs achieved through the use of community-based labs. Factors are reflected in the capitation rates.

The Contractor is responsible for providing updates and reporting on the above programs to EOHHS in a manner and frequency as determined by EOHHS.

14. IHH / ACT and Accountable Entity Waivers

Level 1:

BHDDH and EOHHS have approved the following waivers for The Providence Center:

- Flexible staffing ratios for ACT.
- No minimum program requirements for monthly ACT payments. Therefore, the Providence Center may provide less than four (4) hours of service as required in the standards.

The Contractor may work with provider on alternative payment rates and other alternative arrangements for IHH/ACT.

Level 2:

BHDDH and EOHHS have approved the following waivers for The Providence Center:

- Flexible staffing ratios for ACT.
- The program requirements for ACT do not apply.
- The ACT quality metrics and quality withhold payment do not apply.
- The ACT payment rate as defined by the State does not apply to The Providence Center.

The Contractor may work with the provider on alternative arrangements and other alternative arrangements for IHH/ACT.

Additional Information:

- The Providence Center is required to provide encounter data/shadow billing for all IHH and ACT claims. The claims must include at least one service detail.

15. Incentive Payments Regulations

If the Contractor is eligible for incentive payments, and in accordance with 42 CFR 438 (b) (2), payments under incentive arrangements may not exceed 105 percent of the approved capitation rate since such total payments will not be considered to be actuarially sound. Additionally, per 42 CFR 438 (b) (2) (v), the incentive arrangement must be for a fixed period of time and performance is measured during the rating period under the contract in which the arrangement is applied. 42 CFR 438 (b) (2) (iv) states that participation is not conditional on entering into or complying with an inter-governmental agreement. Please refer to the states quality plan for further information.

ATTACHMENT O

MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY SERVICES FOR CHILDREN

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

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Contractor requirements for mental health and substance use services as set forth in Sections 2.06, 2.08, and 2.09 and
ATTACHMENT A is described below.

MENTAL HEALTH PARITY

Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits ae no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits.

MENTAL HEALTH AND SUBSTANCE USE SERVICES

Contractor commits to providing children a full continuum of mental health and substance use services. Contractor's services will address all levels of need. These include but are not limited to:

ACUTE SERVICES:

Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Emergency Service Intervention:** 24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within 90 days of the execution of this amendment.

- The discharge plan will be shared with the member's pediatrician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.

- The health plan must demonstrate compliance to this requirement within 90 days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

1. Alcohol Related Disorders
2. Anxiety Disorders
3. Mood Disorders

2. **Observation/Crisis Stabilization/Holding Bed:** A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannd meet their basic needs and functions, and who require extended observation in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

3. **Inpatient Acute Hospitalization:** Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24- hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

4. **Acute Residential Treatment:** A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

INTERMEDIATE SERVICES:

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Partial Hospitalization (PHP):** A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

   A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For children and adolescents, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the child's symptoms improve and a transition plan effectively transitions the child back to family, community and school setting. The PHP consults and coordinates the member's care with the child's parent/guardian, other treating providers and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least 20 hours per week for BH and/or SUD
- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.

- A licensed practitioner responsible to supervise program and staff and a treatment plan shall be provided for each member.
- The Contractor shall be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

2. **Day/Evening Treatment:** A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Children and adolescents who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

3. **Intensive Outpatient Treatment (IOP):** A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psychoeducation, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.
- A licensed practitioner responsible to supervise program and staff and a treatment plan shall be provided for each member.

4. **Enhanced Outpatient Services (EOS):** Home/community based clinical services provided by a team of specialized licensed therapists and case managers. (Some examples of EOS clinical specialists include providers with expertise in the treatment of Developmental Disabilities, Sexual Abuse, and Post Traumatic Stress Disorder). The goal of EOS is to offer an effective and clinically supported transition of care from an inpatient or residential setting or to avoid an inpatient or residential admission for high risk members.

Providers offer prompt access to this service and are able to provide varying levels of service intensity (multiple times per day and tapering to multiple times per week) to meet the unique needs of children and their families. This service may be used to assist a child transitioning from an inpatient stay or to prevent an admission.

Minimum program requirements include:

- Home/community based clinical services provided to meet the member's clinical needs. It is recommended that services are provided for up to 5 days per weeks.
- Services are provided to the member based on the member's need. It is recommended that this includes 4 hours per day of service by a multi-disciplinary clinical team.

OUTPATIENT SERVICES:

1. **Traditional outpatient services, including:**

   - Diagnostic evaluation
   - Developmental evaluations
   - Psychological testing
   - Individual therapy
   - Family therapy
   - Group therapy
   - Medication management

2. **Home and Community Based Services for Individuals under Age 21 Years of Age** (as described below):

1. Background and Overview

Home Based Treatment Services (HBTS), Personal Assistance Services & Supports (PASS), Respite, Evidence Based Practices (EBP) and Adolescent Residential Substance Use Treatment are designed for children with complex health needs. These services intended for children with complex health needs have historically been accessible outside of the MCO's scope of benefits through Medicaid Fee- For- Services (FFS). EOHHS intends to integrate all home and community based services for children and adolescents in an effort to meet Rhode Island's goals of the Triple Aim and to provide continuity and appropriate service delivery to children and their families. It is intended that the Contractor will further expand the service array available for children enrolled in the Contractor's Health Plan and fully manage the health care of the whole child within the context of their families. The Contractor commits to providing these services to members, beginning on January 1, 2016. The Contractor must provide these service to any Medicaid member under age 21, per Federal EPSDT regulation. Services are not specific to any particular product line or population but are intended to meet the needs of children with serious or chronic health needs to attain their fullest potential and to remain as independent as possible within their communities. The Contractor shall-

Assess members for medical necessity criteria, based on the guidelines outlined below.

EOHHS will maintain the Cedar Family Center services for both Medicaid FFS members and members enrolled in a health plan. EOHHS has removed the requirement that all members must be evaluated by a Cedar in order to have access to a home and community based service array. Contractor may choose to collaborate with Cedar for care coordination as needed by the child and family.

2. Goals

Specialized programs for children with complex health needs should be provided in a holistic, person and family centered way. Services should be provided to improve member outcomes by integrating social, behavioral health, and physical health needs. For some, selective services will be provided over extended periods of time, to assist with chronic condition management and prevent acute inpatient admissions and transitions to higher costs settings. The overarching goals of these services follow the Triple Aim approach:

Improve Care and Access	• Improve overall health and quality of life of children and families • Improve family ability to manage symptoms/behaviors in the home • Improve ability for children to thrive in their communities
Reduce Cost	• Decrease utilization of the ER • Decrease utilization of higher costs settings such as hospitals or residential placements • Encourage alternative payment methodologies for these services
Improve Quality	• Promote evidence based practices • Encourage provider incentives to improve quality of care

3. Program Description by Service

A. Home Based Treatment Services (HBTS):

HBTS is an intensive home or community based service for children and adolescents who have chronic, moderate, or severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning is significantly compromised. HBTS is a phased system approach that includes in person, high frequency, specialized treatment (including Applied Behavioral Analysis discrete trial interventions) and supervision of direct care staff. HBTS is administered routinely with the child/adolescent and parents/guardians engaged in treatment. Children may require up to 20 hours per week, or more as clinically indicated. Key goals of this treatment are person/family centered and could include: a) Increased ability of caregiver to meet the needs of their child/adolescent; b) increased language and communication skills; c) improved attention to tasks; d) enhanced imitation; e) generalized social behaviors; f) developing skills for

independence; g) decreased aggression and other maladaptive behaviors; and h) improved learning and problem-solving skills. The Contractor is responsible for contracting with providers to provide the level of service indicated in this section and ensure timely and needed access to these services per EOHHS Practice Standards.

Core Components:

HBTS is composed of various service components, including:

Assessment and Treatment Planning

1. Assessment of the functional needs of the child and family, utilization of all referral and collateral information (i.e., IEP, IFSP, contact with providers/teachers, review relevant medical or behavioral health evaluations/records), and maintaining ongoing parent/caregiver/guardian communication.
2. Identification and prioritization of treatment goals and objectives that are written to be clear to families, specific and measurable. Interventions shall be clearly defined and research based. The level of parent participation shall be clear and consistent. Parents/Caregivers/Guardians must sign all proposed Treatment Plans.

    i. HBTS Treatment Consultation Services

    Treatment Consultation is intended to bring specific expertise and direction to the treatment team (i.e., Clinical Supervisor and home-based worker). It can be offered on a broad basis or by using Specialty Consultations from licensed Occupational Therapists (OT), Physical Therapists (PT), Psychologist, or Speech and Language Pathologists (SLP). HBTS Treatment Consultation is available before direct services begin (i.e., Pre-Treatment), during a course of HBTS care (Treatment Consultation and Specialty Consultation), and at the conclusion of HBTS (Post-Treatment).

    ii. Treatment Coordination

    Treatment Coordination represents activities by a team member on behalf of a specific child receiving HBTS services to ensure coordination and collaboration with parents, providers, the medical home, and other agencies (e.g., school, Early Intervention, DCYF or FCCP) including the referral source. Collaboration and communication is ongoing throughout a child's course of HBTS.

    iii. HBTS Direct Services

    HBTS consists of Specialized Treatment and Treatment Support. These services can only be provided to a child by a home-based worker in accordance with an approved Treatment Plan, and under the supervision of a licensed healthcare professional.

    iv. HBTS Specialized Treatment

Specialized Treatment is intensive evidence-based intervention that may take place in the child's home, center, and/or community setting, and requires the participation of parents/guardians. For some children/adolescents, HBTS Specialized Treatment may be ABA discrete trial interventions through approved ABA provider-agencies.

HBTS Specialized Treatment is provided on a continuous basis for an approved number of hours per week. The focus of treatment can include: increasing language and communication skills, improving attention to tasks, enhancing imitation, generalizing social behaviors, developing independence skills, decreasing aggression or other maladaptive behaviors, and improving learning and problem-solving skills (e.g., organization, conflict resolution, and relaxation training). It addresses the development of behavior, communication, social, and functional - adaptive skills, and may reinforce skills included in a child's Individual Educational Plan (IEP) or Individualized Service Plan (IFSP). Goals and objectives are defined, written, and tied to specific methods of intervention and measurement of progress. HBTS is not intended to replace or substitute for educational services.

v. HBTS Treatment Support

For some children and adolescents with moderate to severe functional impairments, the frequency and intensity of Specialized Treatment may become too taxing and result in limited benefits such that Treatment Support is indicated. Treatment Support does not represent a minimization of therapeutic effort and is not equivalent to Respite care. Treatment Support uses a portion of HBTS hours for the purposes of providing structure, guidance, supervision, and redirection for the child.

The inclusion of Treatment Support is intended to facilitate a child's ability to remain at home, maintain activities of daily living, participate in the community, and transition into young adulthood. It encourages and promotes the practice of daily living skills by providing structure, supervision, guidance, and redirection while engaging in cognitive, physical, and social activities that would be typical for a child his/her age. The rationale for using Treatment Support must be clearly articulated and linked to one or more of the following domains:

1. The child's ability to acquire and use information.
2. The child's ability to attend and complete tasks.
3. The child's ability to interact and relate with others.
4. The child's ability to care for him or herself.
5. The child's ability to maintain health and physical well-being, which includes participation in community activities.

vi. Applied Behavior Analysis (ABA) Services

ABA discrete trial interventions are highly specialized and a distinct form of basic behavior therapy principles. It is intended that all children and adolescents be considered eligible for ABA services if it is clinically appropriate. It can be overseen by a Board-Certified Behavior Analyst (BCBA) or a licensed trained

professional (e.g., Psychologist). The use of ABA discrete trial intervention can require additional hours of material preparation, planning, directing and supervising of direct service staff. This may include more hours for Clinical Supervision and Lead Therapy. These additional supports can only be provided for ABA recognized providers.

vii. Lead Therapy (for ABA only)

Lead therapy is regarded as an administrative support for ABA services. It provides for the development and updating of instructional materials, providing support to families in applying instructional strategies, and gathering and managing treatment data.

viii. Child Specific Orientation for Newly Assigned Home-Based Worker

Child specific orientation provides the newly assigned home-based worker with detailed information about a child's condition, treatment goals and objectives, methods of intervention, and other related aspects of care such as observing the child and/or other staff working with the child and family. It is provided by the Treatment Consultant or Clinical Supervisor and with an experienced home-based worker, when applicable, to prepare new staff to work with a child and family already receiving care.

ix. Clinical Supervision of Specialized Treatment and Treatment Support Workers

The Clinical Supervisor is responsible for the duties and actions of direct service staff. Clinical Supervision serves to ensure effective development, implementation, modification, and oversight of the Treatment Plan. It is the responsibility of the provider-agency to maintain clinical supervision throughout a period of treatment authorization. Additionally, the Clinical Supervisor must educate the home-based staff on issues of domestic violence, substance use and risk to child welfare, harassment of home-based staff or any other serious circumstances that may compromise or interfere with treatment. Specific functions of clinical supervision include:

- Observe worker in the home with the child implementing the Treatment Plan on a monthly basis
- Model techniques for staff and/or work with the child
- Instruct workers on proper implementation of treatment interventions
- Analyze treatment data and assess efficacy of treatment
- Address clinical issues and challenging behaviors including a functional behavioral analysis for providing direction to the home-based worker
- Assist in development/revisions of the Treatment Plan and writing of goals and objectives
- Communication and collaboration with others (e.g., school personnel, OT, PT, SLP consultants) regarding treatment
- Attend IEP or IFSP meetings, when indicated, in order to maintain or modify Treatment Plan

- In person consultation to home-based worker and family
- Provide group supervision when there are two or more home-based workers treating a child. Group supervision is necessary to maintain optimal communication and ensure consistent implementation of treatment

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

x. Treatment Intensity and Therapeutic Approach

Treatment intensity refers to the number of direct service hours in an approved Treatment Plan. Upon referral, the provider-agency will assess the child and family's current treatment needs and determine the treatment intensity required. Treatment is to be individualized based upon the clinical needs being addressed and done in collaboration with the child's family and all relevant parties involved in developing a plan of care for the child and family.

Treatment intensity must take into account the following factors:

a. The child's age.
b. The child and family's ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress.
c. Type, nature, and course of presenting condition and diagnosis.
d. Severity of presenting behaviors.
e. Other treatment or educational services being received.
f. Impact on family functioning.
g. Presence of co-existing conditions.
h. Presence of biological or neurological abnormalities.
i. Current functional capacities of the child.
j. Family factors (e.g., parenting skills, living environment, and psycho-social problems).
k. Interaction with other agencies or providers.

xi. Staffing

HBTS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANS screening, including the following:

1. Home-Based Specialized Treatment Worker:
   a. At least 19 years of age
   b. High school diploma/equivalent and two years' experience or currently enrolled in not less than 6 semester hours of relevant undergraduate coursework at accredited college or university
2. Home-Based Treatment Support Worker:
   a. At least 19 years of age
   b. High school diploma/equivalent and one-year experience or Associate's degree in human service field.

3. Clinical Supervisor:
   a. Rhode Island licensed health care professional with established competency working with children with special health care needs. Master's or Doctoral degree.
4. Treatment Consultant:
   a. Rhode Island licensed health care professional in one of the following categories: BCBA, licensed independent clinical social worker, licensed clinical social worker, marriage and family therapist, mental health counselor, psychologist, physical therapist, Occupational Therapist, or Speech and Language Pathologist
5. Treatment Coordinator:
   a. Bachelor's degree at minimum
6. Lead Therapist: (for ABA)
   a. At least 19 years of age
   b. High school diploma/equivalent and two years' experience or an Associate's degree in human service field.

At a minimum, the Contractor is responsible for ensuring that adequate provider access is available for all levels of staffing listed above.

xii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of HBTS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

xiv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to HBTS at intervals defined by EOHHS. Within six months of the executed contract, the State and Contractor will collaboratively identify reportable quality outcome metrics.

xv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Access Point RI (HBTS and ABA Program)

Bradley Hospital (ABA Program)
CBS Therapy (ABA Program)
Family Behavior Solutions, Inc. (ABA Program)
Frank Olean Center (HBTS)
Groden Center (HBTS and ABA Program)
J. Arthur Trudeau (HBTS and ABA Program)
Looking Upwards, Inc. (HBTS)
Momentum, Inc. (ABA Program)
Northeast Behavioral Associates (HBTS and ABA Program)
Ocean State Behavioral (HBTS)
Ocean State Community Resources, Inc. (HBTS)
Perspectives Youth and Family Services (HBTS and ABA Program)
proAbility (HBTS)
Seven Hills (HBTS and ABA Program)
TIDES (HBTS)
United Cerebral Palsy of RI (HBTS)

The contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

B. Evidence Based Practices (EBP):

EBP are Home and Community Based Treatment modalities that include an array of services to meet the continuum of care a child, adolescent, and family needs.

Core Components:

At a minimum, the Contractor is responsible for ensuring that evidenced based practices, such as the services identified above are available to its members and are part of the continuum of care offered by the Contractor.

i. Staffing

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing needed for the specific EBP.

ii. Level of Care Criteria

The Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between Contractors and FFS, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iv. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to the EBP at interval defined by EOHHS. Within six months of the executed contract, the State and Contractor will collaboratively identify reportable quality outcome metrics.

v. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service.

C. Adolescent Residential Substance Use Treatment:

Core Components:
Individualized treatment is determined through comprehensive assessment using ASAM criteria and clinical collaboration. Treatment is strength-based, solution focused utilizing Motivational Interviewing, Cognitive-Behavioral Therapy and evidence based modalities including Dialectical Behavior Therapy and Aggression Replacement Therapy. Programming combines recreation, life skills curriculums and opportunities for 12-step recovery work with the individual, group and family work each client receives. Treatment is specific to maintaining abstinence and relapse prevention while promoting effective functioning in society with medication prescribing and monitoring where indicated. Referrals are received via hospitals, physicians, call centers, treatment programs, RI Family and Drug Courts, Probation and Parole, DCYF and local school systems.

i. Staffing

Clinical Director, Program Director, counselors/clinicians, education coordinator, recreation coordinator and residential support staff.

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

ii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

iii. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to adolescent substance use residential programming at intervals defined by EOHHS. The Contractor is responsible for identifying reportable quality outcome metrics.

iv. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Caritas ARTS Program.

The contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider, if applicable.

D. Personal Assistance Services & Supports (PASS):

PASS is a comprehensive integrated program that includes intermittent, limited, or extensive one-to-one personal assistance services needed to support, improve or maintain functioning in age appropriate natural settings. These specialized consumer-directed services are available to children who have been diagnosed with certain physical, developmental, behavioral or emotional conditions living at home. PASS Services are designed to assist children and youth with attaining goals and identifying objectives within three areas: activities of daily living, making self-preserving decisions, and participating in social roles and social settings. The goals of the services provided are to support the family in helping the child participate as fully and independently as possible in natural community settings and to reach his or her full potential.

This is achieved through maximizing control and choice over specifics of service delivery and the child's family assumes the lead role in directing support services for their child.

Core Components:
PASS is composed of various service components, including:

i. Assessment and Service Planning

PASS Agency coordinator works with the family to assure families have the requisite information and/or tools to participate in a consumer-directed approach and to manage the services. The PASS Agency coordinator assesses the family's ability to effectively participate in the delivery of PASS services throughout an authorized period of care. The Service Plan begins with an assessment of the needs and activities of the child and family based upon their daily routines. From the assessment, flows the identification of goals and objectives with details of Service Plan Implementation and monitoring. Service Plans constitute a written agreement for all involved parties and identify roles and responsibilities of each party (i.e. PASS families, direct service worker(s) and PASS Agency). All goals and objectives in the Service Plan and in the scope of the Direct Service Worker activities must be focused in at least one of the three PASS domains: activities of

daily living, making self-preserving decisions, and participating in social roles and social settings.

ii. Direct Services

Direct Services are one-to-one personal assistance services provided by a Direct Service Worker under the direction of the parent/caregiver/guardian in accordance with an individualized approved Service Plan. Under Direct Services, designated family supervisor(s) will direct the scope, content and schedule of worker activities and evaluate their performance.

iii. Service Plan Implementation

PASS Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

iv. Clinical Consultation

Provides family, Direct Service Workers, and the child with clinical guidance through reviews of goals and objectives, observations of a child's progress, providing recommendations for effective strategies and approaches and for methods for monitoring and tracking progress.

v. Treatment Intensity

Treatment intensity refers to the number of direct service hours in an approved Service Plan. It is the PASS Agency's responsibility to determine the level of treatment intensity necessary to promote the achievement of treatment objectives. Treatment intensity is based on the individual needs of a child. Collaboration with the child's family and all relevant parties involved in developing an individualized plan of care for the child is required and shall be maintained throughout a period of treatment (e.g., HBTS, behavioral health, physician, school personnel, or other agencies). Arriving at a level of treatment intensity must take into account the following factors:

1. The child's age.
2. Ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress.
3. Type, nature, and course of presenting condition and diagnosis.
4. Severity of presenting behaviors.
5. Other treatment or educational services being received.
6. Impact on family functioning.
7. Presence of co-existing conditions.
8. Presence of biological or neurological abnormalities.
9. Current functional capacities of the child.
10. Family factors (e.g., parenting skills, living environment, and psycho-social problems).

11. Interaction with other agencies or providers.

At a minimum, the Contractor is responsible for ensuring that all above services are available to its members and are part of the continuum of care offered by the Contractor.

vi. Staffing

PASS is provided by for a variety of different staff persons, all of whom must successfully pass a BCI and CANTS screening, including the following:

1. Direct Service Worker
   a. At least 18 years of age
   b. High school diploma/equivalent
   c. No financial responsibility for child and does not live in household
   d. Demonstrated ability to carry out specific tasks outlined in service plan

2. PASS Agency Coordinator
   a. Bachelor's Degree in human services or related field
   b. One-year minimum experience
   c. Demonstrated competency working with families of children with special health care needs

3. Clinical Consultant: Rhode Island licensed health care professional with minimum two years' experience working with children with special health care needs
   a. Licensed independent clinical social worker
   b. Licensed clinical social worker
   c. Board Certified Behavior Analyst
   d. Registered nurse with Master's Degree
   e. Psychologist
   f. Physical therapist, occupational therapist, or speech and language pathologist
   g. Mental health counselor
   h. Marriage and family therapist

At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

vii. Level of Care Criteria

After the PASS transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. In order to assure comparability between Contractors and Fee for Service (FFS) Medicaid, the criteria must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for the core components of PASS. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

ix. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to PASS at interval defined by EOHHS. Within six months of the executed contract, the State and Contractor will collaboratively identify reportable quality outcome metrics.

x. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

Access Point RI
Frank Olean Center
Groden Center
J. Arthur Trudeau Memorial Center
Looking Upwards, Inc.
Momentum, Inc.
Northeast Behavioral Associates
Ocean State Behavioral
Ocean State Community Resources, Inc.
Perspectives Youth and Family Services
proAbility
Seven Hills
United Cerebral Palsy of RI

The contractor is responsible for contacting each provider agency and providing education on managed care contracting and managed care billing procedures to the provider.

E. Respite:

Respite services are family directed caregiving supports available for families of children (birth-21) that meet an institutional level of care criteria. Families who are eligible receive an annual allotment of at least 100 hours of respite services. Additional hours may be utilized to prevent the need for more intensive services and supports. Respite agencies manage, hire, and provide payment to respite workers. Respite workers are chosen by the family and the hours may be utilized as determined by the family. The Contractor must offer the family at least 100 hours of respite services, per year.

Core Components:
Respite is composed of two service components, including:

i. Assessment of Safety/Service Plan

Respite agency conducts a brief assessment of child's preferred and allowable activities, methods for communicating, health and safety issues for development of a service and safety plan.

ii. Respite Service

Respite Agency supports family in recruitment, screening, hiring and training of Direct Service Workers and their ongoing employment through payroll administration.

At a minimum, the Contractor is responsible for ensuring that all above components are available to its members and are part of the continuum of care offered by the Contractor.

iii. Staffing

Respite is provided by the following staff persons, including:

iv. Respite Program Coordinator

Minimum Associates Degree and one- year experience working with families of children with special health care needs or at least three years' experience working with families of children with special health care needs.

v. Respite Worker

At least 18 years of age with no financial responsibility for child and does not live in household. At a minimum, the Contractor is responsible for ensuring that adequate provider contracts are available for all levels of staffing listed above.

vi. Level of Care Criteria

After the Respite transition period, the Contractor is responsible for designing level of care/ utilization management criteria for this service. This criterion must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

vii. Payment Methodology

The Contractor is responsible for designing an innovative payment method for these services. Methodology must be submitted to EOHHS for review and approval, prior to the Contractor's implementation.

viii. Quality/Outcome Metrics and Reporting

The Contractor is responsible for providing EOHHS with reporting specific to Respite at interval defined by EOHHS. Within six months of the executed contract, the State and Contractor will collaboratively identify reportable quality outcome metrics.

ix. Provider Network

The Contractor is responsible for maintaining a robust provider network to provide this service. At the minimum, the Contractor must contract with the following providers:

The Autism Project
Access Point RI
The Groden Center
J. Arthur Trudeau Memorial Center
Northeast Behavioral Associates
Ocean State Behavioral
Ocean State Community Resources, Inc.
Seven Hills Rhode Island

The contractor is responsible for contacting each provider and providing education on managed care contracting and managed care billing procedures to the provider.

4. EOHHS Certification Standards

EOHHS has designed certification standard for its Medicaid FFS providers. The Contractor shall use these certification standards as a guideline in designing the Contractors' programs. To assure comparability, the Contractors programs shall not deviate substantially from the EOHHS Certification standards. All of the Contractors program standards and guidelines must be provided to EOHHS for review and approval.

5. Court Ordered Treatment

Court ordered treatment will only be covered when determined medically necessary by the Contractor. The Contractor is only responsible for covering treatment provided by in-network providers.

6. Services with Existing Referral Lists

There is an existing referral list for HBTS (including ABA services). The Contractor will continually evaluate all individuals on the referral list and provide them with suitable services which address their unique clinical needs. The Contractor shall be responsible for reporting to EOHHS monthly until such time that no members remain on the referral list.

7. Reductions in Savings:

EOHHS has assumed savings for children's behavioral health programs in the current rates and contracts. Saving estimates have been reduced to ensure timely access to services and increase provider participation. The contractor will insure appropriate reimbursement adjustments to children's Home Based Therapeutic Services (HBTS) and Applied Behavior Analysis (ABA providers. It is the expectation that the Contractor provides services to all children currently on the waitlist as described in the section above.

ATTACHMENT P

BEHAVORIAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

ATTACHMENT P
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

The following provides a description of the Integrated Health Home Program (IHH) and the Assertive Community Treatment Programs (ACT). These services are specific to individuals with serious mental illness. The second part of the document refers to the continuum of mental health and substance use services. These services shall be provided to any adult member, based on need. EOHHS, BHDDH, and the Contractor will work together to transition these services from Fee-for-Service into managed care. EOHHS recognizes as this transition occurs, the program and service features may change. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

Adults with serious mental illness require specialized programs that deliver recovery-oriented care, addressing all clinical needs both behavioral and medical. These specialized programs are responsible for ensuring integration of care which includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports. The performance of these programs will be measured and the goal is improved access to high quality community based services and decreased costs.

The specialized programs will be for adults with a range of serious mental health illness identified based on diagnostic characteristics. The specialized programs described in this document which will be carried out by the Community Mental Health Organizations (CMHOs) licensed by BHDDH are referred as: Assertive Community Treatment (ACT) and Integrated Health Homes (IHH). Program monitoring and evaluation by the Contractor is required to ensure validity to the model and the effective implementation of responsibilities and functions by the Managed Care Organizations and the CMHOs. The program will be supported by BHDDH regulations.

It is the State's expectation that for those members who are active with a Health Home, the care manager on site at the Health Home will be the Lead Care Manager for that member. Contractor's care management staff will coordinate between the Health Home and any necessary physical health care a member may need. Contractor shall have a designated Lead Care Coordinator or Care Manager to work directly with the CMHO and OTP Health Homes. The Contractor shall employ predictive modeling tools that identify and stratify members at risk. If an at-risk member is identified, they will be referred to a Health Home.

Contractor shall have policies and procedures that document how Contractor will conduct transitions of care and hospital discharge activities, to ensure all appropriate medical, social, and behavioral health needs are met when a member transitions back to the community.

2. Goals

The specialized programs for adults with serious mental illness will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system.

Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	• Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	• Ensure that a sufficient range of community based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	• Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Mental Health Parity

Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits ae no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits.

Program Description

Target Populations

Eligible participants in ACT or IHH must be 18 years or older and are actively enrolled in the following Medicaid product lines: RIte Care, Medicaid Expansion, Rhody Health Partners (RHP), and Rhody Health Options (RHO).

Participants are initially defined by their diagnostic characteristics, specifically a primary DSM

V/ICD-10 mental health diagnosis. To be eligible for ACT and IHH participants must also meet the appropriate level of acuity as defined by the State approved standardized assessment tool Daily Living Activities Functional Assessment (DLA).

- ACT participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- Individuals who do not meet diagnostic criteria, but require IHH services due to significant functional impairment as measured by the state approved standardized assessment tool, may be admitted to the program through an appeals process established by the State.

Core CMHO Functions and Responsibilities

The CMHOs will carry out the following functions under both ACT and IHH Programs:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the standardized tool, DLA, to identify participant.
- Based on Assessment score, determine and place individual in appropriate specialized program level of service: IHH or ACT. Individuals that do not meet IHH or ACT will not be assigned to the programs and but remain eligible for services and care management in the community.
- Develop a person-centered, individualized Care Plan
- For all Health Home admissions, discharges and transfers, a State approved enrollment form must be completed and kept in the client's medical record. If a client is already enrolled in a Health Home program it is up to the Provider to coordinate with the client's current Health Home Provider
- Carry out treatment and recovery services with fidelity to the ACT model of care
- Carry out treatment and recovery services in the IHH model of care
- Actively use Current Care for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the Current Care program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Collaborate to create new delivery system capacity as needed through on-going evaluation of the needs of the system.

- Work with Contractor's care management staff to facilitate access to the member's PCP and specialty medical providers.
- Work with Contractor's utilization review staff to ensure timely access to follow-up care, post inpatient psychiatric hospitalization, including medication reconciliation.
- Submit required Contractor and EOHHS metric reporting and data exchange
- Coordinate with the Opioid Treatment Provider (OTP) Health Home Program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, IHH and OTP Health Home
- Notify Contractor and BHDDH of staffing changes impacting the CMHO's ability to provide the services required for IHH or ACT within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The ACT and IHH specialized programs both use a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. Care is provided with fidelity to the evidence-based practices of ACT and IHH. The model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from mental illness. Active treatment and supports are provided with cultural competence.

Program Definitions

Assertive Community Treatment (ACT) Services provided through RI Integrated Health Homes (IHH) have the responsibility to coordinate and ensure the delivery of person-centered care; provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. Regardless of the level of care, these outcomes are achieved by adopting a whole person approach to the consumer's needs and addressing the consumer's primary medical, specialist and behavioral health care needs; and providing the following comprehensive/timely services:

- Comprehensive care management;

- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The ACT team is available to provide services 24 hours per day seven days per week, 365 days per year. An ACT team is best conceptualized as continuous care team that functions as a vehicle to provide an array of clinical services or practical needs a person requires. As the provider of most of the services, the continuous care team assures that the services are integrated and provided in the context of the client's current needs, with all activities directed toward helping the client to live a stable life of quality in the community. A major focus of the team is to help the client to gain the skills and confidence needed to move toward greater degrees of independence.

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

IHH activities are focused in four areas:

1. **Care coordination and health promotion**

   Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, collaborate with primary and specialty care providers as required and provide education about medical medications (e.g. educating through written materials, etc.). The Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. **Chronic condition management and population management**

The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team.

- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;

- Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;

- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their psychiatric and medical issues to live in the community. This includes:

    - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).

    - Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

    - Provide ongoing assessment, problem solving, side-by-side services, skill training, supervision (e.g. prompts, assignments, monitoring, and encouragement) and environmental adaption to assist support client to maintain housing).

    - Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services.

    - Develop skills related to reliable transportation (help obtain driver's license, use of mass transit, arrange for cabs.

- Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client 's social and interpersonal activities in community settings) e.g. Plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including side-by-side support and coaching.

- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:

  - Support the client to consistently adhere to their medication regimens (e.g. daily scheduling, delivering and supervision of medication regime, telephone prompting, Motivational interviewing, etc.), especially for clients who are unable to engage due to symptom impairment issues.

  - Accompanying clients to and assisting them at pharmacies to obtain medications.

  - Accompany consumers to medical appointments, facilitating medical follow up.

  - Provide side-by-side support and coaching to help clients socialize (e.g. going with a client to a baseball game, etc.) - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

3. Comprehensive transitional care

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will communicate and ensure collaboration between consumers, professionals across sites of care and Contractor's care management and utilization review staff potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

a. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

b. Upon hospital discharge (phone calls or home visit):

   i. Ensure that reconciliation of pre-and post-hospitalization medication lists is completed.

   ii. Assist consumer to identify key questions or concerns.

iii. Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow- up appointments.

iv. Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).

v. Contractor's care management and utilization review staff will work with the IHH team to review transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to IHH consumers – to clarify all outstanding questions.

c. Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

IHH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized psycho-education about the client's illness and the role of the family and their significant people in the therapeutic process. Also, to assist clients with children regarding service coordination (e.g. services to help client fulfill parenting responsibilities; services to help client restore relationship with children, etc.).

IHH peer support specialists will help IHH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support serves to validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

a. Help clients establish a link to primary health care and health promotion activities.

b. Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.

c. Assist clients in making behavioral changes leading to positive lifestyle improvement.

d. Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment

The CMHOs are expected to use a single, standardized assessment tool approved by the State. Assessments based on other tools will not be accepted.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or nursing home.

Plan of Care

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measureable, realistic and time sensitive goals. The following are required:

- Plan of care developed within 30 days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

Reporting

A complete listing of quality and monitoring measures is listed below. The State reserves the right to make modifications to required data elements and aggregate reports.

5. Assertive Community Treatment (ACT) and IHH Requirements

The requirements of ACT and IHH have several shared requirements but differ in the characteristics of the participants and the level of service intensity, as determined by the functional level score. ACT and IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.

Service Requirements

Participants are outreached by members of the ACT Team continually to engage in care to the maximum extent necessary to achieve individual goals. If a member refuses care or declines participation for 90 days, the CMHO must notify the Contractor to review the Care Plan.

Participants are outreached and engaged by members of the IHH Team over the course of each month. The IHH Team members must be flexible and available to meet more frequently when needed. The IHH Team Leader is available 24 hours/day 7 days a week if needed.

The ACT and IHH Teams provides or coordinates the following services:

• Crisis Stabilization Services 24/7
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Medication Management Medication administration, monitoring and reconciliation
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Substance Use Treatment (for ACT participants only)

• Supported Employment/Schooling Assessment and Assistance
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Peer Support and IADL Support Services
• Education, Support, and Consultation to Clients' Families and Other Major Supports

A. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and the greater ACT/IHH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Stabilization

Crisis stabilization shall be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner.

These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service.

A. Therapy

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and response to treatment.

2. Individual and family Pychoeducation regarding mental illness and the effects and side effects of prescribed medications

3. Symptom-management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.

4. Individual, group and family supportive therapy

5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

B. Medication Prescription, Administration, Monitoring and Documentation

The ACT/IHH team psychiatrist or registered nurse shall provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

C. Dual Diagnosis Substance Use Disorder Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client-determined goals. This shall be provided by an addiction specialist and include but is not be limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)
2. Assessment (e.g., stage of readiness to change, client-determined problem identification)
3. Motivational enhancement (e.g., developing discrepancies, psych education)
4. Active treatment (e.g., cognitive skills training, community reinforcement)
5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

D. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.

b. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

c. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.

d. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.

e. On-the-job or work-related crisis intervention.

f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

g. Job Development

h. On-site supports as needed

i. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)

j. Job coaching

E. Activities of Daily Living/ADL's

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

a. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)

b. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

c. Carry out personal hygiene and grooming tasks, as needed

d. Develop or improve money-management skills

e. Use available transportation

f. Have and effectively use a personal physician and dentist

F. Natural Supports and Social/Interpersonal Relationship Identification

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and

coaching; and organizing individual and group social and recreational activities to structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support required to:

a. Improve communication skills, develop assertiveness, and increase self-esteem

b. Develop social skills, increase social experiences, and develop meaningful personal relationships

c. Plan appropriate and productive use of leisure time

d. Relate to landlords, neighbors, and others effectively

e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

G. Peer Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self- imposed stigma. Services include:

1. Peer counseling and support

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

H. Instrumental Activities of Daily Living Support Services (IADL)

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and Dental services

2. Safe, clean, affordable housing

3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)

4. Social services

5. Transportation

6. Legal advocacy and representation

I. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1) Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process

2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people

3) Ongoing communication and collaboration, face-to-face and by telephone, between the ACT/IHH team and the family

4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery

5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

   a) Services to help clients throughout pregnancy and the birth of a child

   b) Services to help clients fulfill parenting responsibilities and coordinate services for the child/children

   c) Services to help clients restore relationships with children who are not in the client's care and custody

J. Care Transitions

The ACT/IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.

2. Upon hospital discharge (phone calls or home visit):

   - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.

   - Assist consumer to identify key questions or concerns.

   - Ensure the client understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent worsening of health conditions and facilitate the scheduling of all follow-up appointments.

- Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.

3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The Team Lead for an ACT team must be a licensed clinician. The Team Lead for an IHH team can be licensed as a Registered Nurse, or have a Master's in Social Work. The assignment of the appropriate type of Lead CM is based on the level member's level of needs. In addition to the Team Lead, the ACT Team and IHH teams are expected to have a staff as defined in the *IHH Provider Manual.*

Reimbursement Arrangement
The provider is reimbursed based on a bundled rate for their ACT or IHH participants and MCO Fee for Service for selected services.

Billing for ACT will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the MCOs for MCO clients and for the State for Medicaid FFS clients. If a service provided for in the bundle is billed separately from the bundle, by the ACT provider or another provider, the claim shall deny.

Individuals involved in the MHPRR program are not able to enroll in ACT. ACT billing is not allowed for persons in institutionalized settings. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than 30 days, the provider shall report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

Billing for IHH will consist of the specified IHH code as well as other clinical services provided apart from the bundle. The IHH bundled rate is for care coordination activities only, and does not include any clinical services. IHH can be billed while an individual is in an institutionalized setting. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than 30 days, the provider shall report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

ACT Bundled Services	ACT MCO Fee for Service
• Crisis Stabilization Services including 24/7 access	• Clubhouse
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports	• Methadone

• Recovery& Rehabilitation skills	
• Supported Employment/Schooling	
• Case Management- Identification and engagement of natural supports and Social relationships	
• Care Coordination- Outreach and engagement • Medical and Substance Use Treatment Coordination Activities	
• Team Rounding	
• Peer Support and IADL Support Services	
• Care Transition – hospital, incarceration or nursing home to home	
• Outpatient Clinical services provided at the CMHO including: Medication Management Medication administration, monitoring and reconciliation, Individual, Group and	
• Medication management including reconciliation	
• Substance Use Treatment (for ACT participants only)	

In general, the IHH program billing will encompass:

• Crisis Stabilization Services including 24/7 access	• Residential Treatment • Substance Use Treatment
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports	• Outpatient Clinical services provided at the CMHO and in community- Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy
• Recovery& Rehabilitation skills	• Clubhouse
• Case Management- Identification and engagement of natural supports and Social relationships	• Supported Employment/Schooling assessment and assistance

• Care Coordination-Care Transition – hospital, incarceration or nursing home to home	
• Medical and Substance Use Treatment Coordination Activities	
• Team Rounding	
• Care Transition – hospital, incarceration or nursing home to home	

Contractor Responsibility:
The Contractors will support the following:

- Provide CMHOs with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with CMHOs.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the CMHOs with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements as specified by EOHHS.
- The Contractor will adhere to a quality performance payment methodology and process that could include recoupments or withholds, as specified by EOHHS.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor shall hold the member harmless.
- The Contractor shall ensure that the CMHO's are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.

Integration with Rehabilitation Practices

Additional services not mentioned above for ACT/ IHH will integrate clinical treatment, services, and Rehabilitation practices including:

- Integrated Dual Diagnosis Treatment (substance use and mental illness), an evidence based practice
- Mental Health Psychiatric Rehabilitation Residences (MHPRR)

Value-based Purchasing & Monitoring

The Contractor will adhere to a quality performance payment methodology and process that may include recoupments or withholds, as specified by EOHHS.

The information collected from each measure will be used for program monitoring and must be provided based on the parameters. These measures will be routinely reviewed and modified, based on industry trends.

6. In Plan Benefits

MENTAL HEALTH PARITY

Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits ae no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits.

1. MENTAL HEALTH AND SUBSTANCE USE SERVICES

Contractor commits to providing all Medicaid managed care adults a full continuum of mental health and substance use services. Contractor's services will address all levels of need. Contractor shall have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community based providers. All services should be provided to any adult member, as needed.

Services are not restricted to a specific pay level or category (such as an SPMI designation). The following provides an example of services that a CMHC or equivalent provider should provide. These include but are not limited to:

A. ACUTE SERVICES:
Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. **Emergency Service Intervention:**

24 hour/7 days a week; face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within 90 days of the execution of this amendment.

- The discharge plan will be shared with the member's physician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.

- The Contractor must demonstrate compliance to this requirement within 90 days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

- Alcohol Related Disorders
- Anxiety Disorders
- Mood Disorders

2. **Observation/Crisis Stabilization/Holding Bed:**

A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation and treatment in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

3. **Inpatient Acute Hospitalization:**

Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be

safely or effectively treated in a less intensive level of care.

4. **Acute Residential Treatment:**

A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, and 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday-Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

B. INTERMEDIATE SERVICES and OUTPATIENT

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. Partial Hospitalization (PHP):

A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For adults, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the adult's symptoms improve and a transition plan effectively transitions the adult back to the community. The PHP consults and coordinates the member's care with other treating providers, and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least 20 hours per week for BH and/or SUD
- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.
- A licensed practitioner responsible to supervise program and staff and a treatment plan shall be provided for each member.
- The Contractor shall be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

2. Day/Evening Treatment:

A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Adults who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

3. Intensive Outpatient Treatment (IOP):

A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:

- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate based on the member's needs.

- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.
- A licensed practitioner responsible to supervise program and staff and a treatment plan shall be provided for each member.

4. ACT & IHH:

Integrative behavioral and physical health care management model. Assessment, evaluation to identify member's behavioral and physical health needs. Care plan developed based on members identified needs with the goal of client stability and long-term community tenure. Coordination through regular contact and correspondence with primary care, social support, family, and treatment providers the member is involved with. Assist member in accessing social supports, vocational training and support, medical and behavioral health treatment, education training and support as identified through members' assessment and care plan. Case Manager must assist a member with transition from any 24-hour level of care or to prevent an admission. Case Management is delivered by adequately trained agency staff in accordance with applicable program specifications, State certification or licensing requirements, in addition to applicable MCO credentialing requirements.

The contractor shall reimburse these services in a manner defined by the State.

5. Peer Support/Recovery Coach:

A personal guide and mentor for people seeking or in recovery. The peer support/Recovery Coach assists to remove barriers and obstacles, and links the recovering person to the recovery activities and supports.

6. Clubhouse:

The Clubhouse International model has been recognized by SAMHSA as an Evidence Base Practice for those with severe and persistent mental illness. Clubhouse has community structure, evidence based practice, led by peers, recovery model with a focus on employment, wellness, and development of a community support network.

The Contractor shall reimburse these services in a manner defined by the State.

Clubhouse services should include a minimum of 3 hours per service, at least 1 time per week. At a program level, 25% of all members in the program must have an employment outcome of either supported employment, transitional employment or independent employment.

7. Integrated Dual Diagnosis Treatment for Substance Use Disorders:

Care management services provided in accordance with an approved treatment plan to ensure members with primary substance use maintain and build stability, recovery

capital, and continued community tenure.

8. General Outpatient:

Clinical services inclusive of individual, group, family, crisis intervention, diagnostic evaluation, psychological testing, and medication evaluation and management. Treatment can be conducted in an office, home-based or community setting. Member has access to full continuum of Behavioral Health and Substance Use benefits offered by the Contractor (PHP, IOP, etc.) Clinical services are delivered by adequately trained behavioral health professionals in accordance with applicable program specifications, State licensing requirements, in addition to applicable Contractor.

9. Center of Excellence Program (COE):

Through the work of the Governor's Opioid Overdoes Prevention and Intervention Task Force, BHDDH will certify providers that meet the established COE certification standards. EOHHS will work with CODAC, and future providers who become certified, to ensure that proper arrangements are in place to allow COE providers to bill medication via J-codes or other methods that will allow them to dispense medication to members at their facility rather than prescribe to the member for self-management, under a point of sale system.

The program is reimbursed by fee for service for managed care members, with the exception of the medications (table or films) which is currently in the formulary of the Contractor and is a benefit for their members.

C. LONG TERM RESIDENTAL PROGRAMS

Long Term SUD Residential Services:

Contractor is required to contract with and support the SSTAR Birth Residential Program. This requirement includes but is not limited to a minimum six (6) month length of stay for the family unit. EOHHS reserves the right to review and approve any prior authorization process required by Contractor.

Services must meet ASAM Level 3.5, Level 3.3, or 3.1

A. ASAM Level 3.5 Clinically Managed High- Intensity Residential:
Level 3.5 provides a structured, therapeutic community environment focused on addressing member life skills, reintegration into the community, employment, education, and recovery.

Minimum Requirements:

- Member meets at least all 3.5 ASAM level criteria.

- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least12 clinical services per week including individual, group, & family, based on the member's need.

B. ASAM Level 3.3 Short- Term Clinically Managed- Medium Intensity:
Level 3.3 is a non- acute residential level of care that focuses on member stabilization, integration, employment, education, and recovery. A component of member treatment may focus on habilitation due to discharge from institutional level of care.

Minimum Requirements:
- Member meets all 3.3 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least12 clinical services per week including individual, group, & family, based on the member's need.

C. ASAM Level 3.1 Clinically Managed Low- Intensity Residential Services:

Minimum Requirements:
- Member meets at all 3.1 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 5 clinical services (1 hour per week of clinical treatment and 4 group and/or family sessions) per week including individual, group, & family, based on the member's need.

Mental Health Psychiatric Rehabilitative Residential (Group Home and Supportive Housing)

A Mental Health Psychiatric Rehabilitative Residence (MHPRR): is a licensed residential program that provides 24-hour staffing for a sub-population of the Integrated Health Home clients.

A physician must authorize all MHPRR services.

The "24-hour staffing" requirement means that the Provider must provide staff coverage 24 hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff is on site for these programs.

The service elements offered by a residential program include to the following based on each resident's individualized recovery-focused treatment plan:

- Mental health therapeutic and rehabilitative services for the resident to attain recovery
- Medication prescription, administration, education, cueing and monitoring
- Educational activities (appropriate to age and need)
- Menu planning, meal preparation and nutrition education

- Skill training regarding health and hygiene
- Budgeting skills training and/or assistance
- Community and daily living skills training
- Community resource information and access
- Transportation
- Social skills training and assistance in developing natural social support networks
- Cultural/Spiritual Activities
- Limited temporary physical assistance, as appropriate

In addition, each residential program provides the following for its residents:

- A homelike and comfortable setting
- Opportunities to participate in activities not provided within the residential setting
- Regular meetings between the residents and program personnel
- A daily schedule of activities
- Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age.
- Provisions for external smoking areas, quiet areas, and areas for personal visits

Supervised Apartments: A Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A) is a licensed residential program which provides 24-hour staffing for IHH clients in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services. Beds may be designated as Intensive, Specialty, Basic, Crisis/Respite, or any combination thereof.

Specific services may include, but are not limited to:

a) Medication: Education, administration and monitoring;
b) Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized treatment planning and skill teaching; income maintenance; and medical care assistance
c) Limited physical assistance as required: Mobility; assistance with non-injectable medications; dressing; range-of-motion exercises; transportation; and household services;
d) Skill assessment and development: Personal hygiene; health care needs; medication compliance; use of community resources; social skills development and assistance; support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized community activities.

The "24-hour staffing" requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff shall be on site. Due to the complexity of these populations, staffing ratios are expected to be greater than traditional MHPRR settings. In addition, group home rules and expectations, levels of supervision and unaccompanied off-site travel will be specifically designed to address the needs of the population.

Target Population:

Services are for adults with complex mental illness who are stable and require specialized rehabilitation services versus basic MHPRR services, in order to continue on their recovery journey. Need indicators for placement will be based on:

- History of Risk of harm to self to others
- Unpredictable behavior and likelihood of relapse
- Motivation and capacity in the areas of self-management
- Socialization
- Mental Health Court Order for residential services.

The Contractor shall reimburse MHPRR facilities at a rate defined by EOHHS.

Quality/Outcome:

Through chart audits at the CMHC, members in MHPRR should routinely attend all care management and integrated BH and medical services.

I. LEVEL OF CARE CRITERIA BASED UPON MEDICAL NECESSITY

Contractor will provide descriptions of services and treatment settings. The criteria for medical necessity must be compliant with the medical necessity definition contained in Section 1.72 of the Contract and include admission, continuing stay and discharge criteria for each.

II. EARLY IDENTIFICATION AND ACCESS

Contractor will have defined methods to promote access to care and for early identification of adults with behavioral health needs, including:

1. Identification of members who may be in an inpatient setting and who will require intensive outpatient services following and to facilitate discharge,

2. Direct referral by a family member or other health care provider.

III. ACCESSIBILITY, AVAILABILITY, REFERRAL AND TRIAGE

The behavioral health program will have defined performance criteria for accessibility, availability, referral and triage that meet and/or-exceed NCQA standards.

IV. PROVIDER NETWORK AND NETWORK ADEQUACY

Contractor shall develop and monitor behavioral health provider network standards, subject to review by the Department, to ensure the full continuum of behavioral health needs is met on a timely basis and to promote geographic accessibility.

V. TRANSITION PLAN

1. The Contractor is required to honor all prior authorizations for the period of the

authorization and with the provider authorized.

2. The Contractor will complete a readiness process approved by the state prior to IHH program implementation
3. The Contractor will complete a review and identify and report to EOHHS on:
    a. IHH
    b. ACT
    c. A Community Health Team (CHT)
    d. Patient Medical Centered Medical Home (PCMH)

The Opioid Treatment Program Health Home Program Description

The following provides a description of the Opioid Treatment Program Health Home (OTP HH). These services are specific to individuals with opiate dependence disorders who have or are at risk of chronic physical illnesses. The second part of the document refers to the continuum of mental health and substance use services. These services shall be provided to any adult member, based on need. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

The Opioid Treatment Program Health Home Program

The Opioid Treatment Program (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination, monitor chronic conditions, enhance coordination of physical care and treatment for opioid dependence, and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers.

OTP Health Home(s): as the fixed point of responsibility to coordinate and ensure the delivery of **person centered care,** the OTP Health home staff ensure and provide timely post discharge follow-up and coordination with other behavioral health providers and primary care providers in the delivery of medical services to the member. The OTP Health Home places emphasis on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and better alignment with standards of care for chronic medical conditions such as Hepatitis C, HIV, Diabetes, Asthma, and COPD.

Patient Eligibility

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Provider Eligibility
The Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) licenses Opiate Treatment Programs and OTP Health Homes.

2. Goals of OTP HH

The specialized programs for adults with opioid dependence and co-occurring chronic conditions or risk of chronic conditions will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This OTP Health Home program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	• Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	• Ensure that a sufficient range of community based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	• Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Program Description

Patient Eligibility

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Core Functions and Responsibilities of OTP Health Home Providers

The OTP Health Homes will carry out the following functions:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the BHDDH-approved OTP Eligibility Checklist form. Based on the finding on the checklist and a bio-psychosocial assessment, the provider will determine and place the individual in the OTP Health Home. Develop a person-centered, individualized Care Plan
- Carry out treatment and recovery services in the OTP Health Home OTP HH model of care
- Actively use CurrentCare for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the CurrentCare program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Submit required metric reporting and data exchange to the Health Home Administrative Coordinator
- Coordinate with the Integrated Health Home and ACT program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, OTP HH and OTP Health Home
- Notify Contractor and BHDDH of staffing changes impacting the OTP Health Home's ability to provide the services required for OTP Health Home OTP HH within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The OTP Health Home is a OTP HH specialized program that uses a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. The OTP HH model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from addiction and lead healthier lives and manage their other chronic conditions. Active treatment and supports are provided with cultural competence.

Program Definitions

The OTP Health Home services are defined below:

- Comprehensive care management;
- Care coordination and health promotion;

- Comprehensive transitional care from inpatient to other settings, including follow-up;
- Individual and family support, which includes authorized representatives of the consumer;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The OTP Health Home (OTP HH) is built upon the evidence-based practices of the patient-centered medical home model. The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses. OTP Health Home is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. OTP Health Home uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

OTP HH activities are focused in four areas:

1. Care coordination and health promotion

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, the primary care manager will collaborate with primary and specialty care providers as required and provide education about medications (e.g. educating through written materials, etc.). The OTP Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. Chronic condition management and population management

The OTP HHOTP HH team supports its consumers as they participate in managing the care they receive. Interventions provided under OTP HH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their opiate addictions and their life situations;

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of their opiate addiction and other chronic medical illnesses as advised by the client's primary/specialty medical team.

- Assisting the client in locating and effectively utilizing all necessary community services to address the client's medical, social and psychiatric needs and ensuring that services provided are coordinated with those provided through physical health care professionals;

- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to address their symptoms of addiction. Activities include:

- Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).

- Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

- The OTP HH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps OTP HH's improve their care delivery system, to the benefit of each OTP HH clients receiving care.

3. Comprehensive transitional care

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The OTP HH team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
- Assist consumer to identify key questions or concerns.

- Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow-up appointments.
- Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Review with the OTP HH team transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to OTP HH consumers – to clarify all outstanding questions.
- Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

OTP HH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized substance use education about the client's opiate addiction and other chronic illnesses and the role of the family and their significant people in the therapeutic process.

OTP HH recovery support specialists will help OTP HH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Recovery support serves will validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

- Help clients establish a link to primary health care and health promotion activities.
- Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.
- Assist clients in making behavioral changes leading to positive lifestyle improvement.
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment

The OTP Health Home Providers will use the BHDDH-designed checklist to assess clients' needs for OTP Health homes.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or detoxification program.

Plan of Care

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measureable, realistic and time sensitive goals. The following are required:

- Plan of care developed within 30 days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

5. OTP HH Reporting Requirements

The OTP HH Reporting Requirements are managed by the OTP Health Home Administrator and coordinated with BHDDH and the OTP HH providers. All reports must be submitted to EOHHS at a frequency defined by EOHHS.

6. Service Delivery and Coordination

The OTP HH Teams provide or coordinate the following services:

• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Education, Support, and Consultation to Clients' Families and Other Major Supports

7. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and other members of the OTP HH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

8. Therapy

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's opiate addiction and response to treatment.
2. Individual and family education regarding opiate addiction and the effects and side effects of prescribed medications
3. Addiction management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her opiate addiction and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

9. Medication Prescription, Administration, Monitoring and Documentation

The OTP HH team psychiatrist or registered nurse shall provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

10. Contractor Responsibilities

The Contractor is responsible for offering contracts to all EOHHS specified OTP HH providers. The Contractor shall pay a specified rate to each provider for OTP HH services as directed by the EOHHS. The Contractor is responsible for following all guidance material distributed by EOHHS relating to this program, including the *OTP HH Billing Manual.* The Contractor shall not pay less than currently established rates but may bundle of provide global rates, with the approval of EOHHS."

11. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
2. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
4. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
5. On-the-job or work-related crisis intervention.
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
7. Job Development
8. On-site supports as needed
9. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
10. Job coaching

12. Ensuring Safe and Stable Housing

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

13. Natural Supports and Social/Interpersonal Relationship Identification

Provide opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

14. Recovery Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery.

1. Recovery counseling and support

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

15. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's opiate addiction and chronic illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the OTP HH team and the family
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
   a. Services to help clients throughout pregnancy and the birth of a child
   b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
   c. Services to help clients restore relationships with children who are not in the client's care and custody

16. Care Transitions

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
   - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
   - Assist consumer to identify key questions or concerns.
   - Ensure the client understands medications, their potential side-effects, is knowledgeable about indications if their condition is worsening and how to respond, and is educated on how to prevent worsening of health conditions.

- Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.

3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The OTP Health Home staff is made up of the following multi-disciplinary complement of staff:

- The OTP Health Home team staff composition required to provide services, based on a population of one hundred twenty-five patients (125) per team, is outlined below. *Any deviation from that staffing pattern will require a written proposal to the Department for approval that includes clinical and financial justification.*

Qualifications:	**Health Home FTE***
Master's Level Team Coordinator	1.0
Physician	0.25
Registered Nurse	1.0
Case Manager – Hospital/Healthcare Liaison	1.0
Case Manager	1.0
Pharmacist	0.10
Total Personnel	**4.35**

Reimbursement Arrangement
The provider is reimbursed based on a bundled rate for their OTP HH participants.

Billing for OTP Health Home will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the Contractor for MCO clients and for the State for Medicaid FFS clients.

Billing for OTP HH will consist of the specified OTP HH code as well as other clinical services provided apart from the bundle. The OTP HH bundled rate is for care coordination activities only, and does not include any clinical services or Medication Assistance Treatment (MAT) services. OTP HH can be billed while an individual is in an institutionalized setting. Refer to the *OTP HH Program Description* for detailed information on billing.

Contractor Responsibility:

The Contractors will support the following:

- Provide OTP Health with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.

- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the OTP Health Homes with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements based on a reporting calendar.
- The Contractor will adhere to the withhold payout requirements based on a reporting calendar.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor shall hold the member harmless.

The Contractor shall ensure that the OTP Health Homes are submitting HIPAA compliant claims data for services delivered under the OTP HH and ACT bundles.

ATTACHMENT Q

CARE MANAGEMENT PROTOCOLS FOR ALL MEMBERS

Rhode Island Executive Office of Health and Human Services (EOHHS)
Care Management Protocols for All members

The overriding goal of the State is to provide eligible members access to quality services and supports tailored to their needs that maximize their health care status, promote their independence, and maintain their quality of life in the most cost-effective manner. To this end, the Contractor shall be required to develop and maintain policies and procedures directed at this goal that are approved by EOHHS. The Contractor shall comply with all State and Federal legal, administrative and programmatic requirements related to these programs and adhere to the provisions of the Contract.

1. INTRODUCTION

Health Plans are required to comply with EOHHS Care Management Protocols for members covered under this Agreement. The Contractor shall have a care management strategy inclusive of a program description and established policies and procedures that set forth the Contractor's approach to compliance. This shall include policies, procedures and criteria/content for identifying and defining those at risk, conducting Health Risk Assessments and for providing Short-Term care coordination and Intensive Care Management Services. Contractor's policies and procedures are subject to review and approval by EOHHS.

In addition to specific health needs, these enrollees and their families, guardians, or adult caretakers may need special assistance in accessing needed services, inclusive of behavioral health, and other community and social supports and services.

The level and type of assistance needed by members and their families, guardians, and adult caretakers will vary considerably. For many members, enrollment into the Health Plan and the ability to access the plan's existing resources will be sufficient. For others, assistance and support may be needed to meet immediate service delivery needs for continuity of care or accessing services. For others, more intensive needs may be present, calling for a more intensive review of needs and care management.

A primary focus of the Health Plan's Care Management program will be:

2.16.04 To identify members with significant health and social needs that are at high risk of poor health outcomes who may require care management services, such as children with special health care needs and individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged form correctional facilities.

2.16.05 To employ the use of predictive modeling tool and analytic to continually identify member at risk for becoming high risk or high utilizers.

2.16.06 To provide Short Term care coordination or Intensive Care Management to those requiring these services.

2.16.07 To engage and empower members in the process

2.16.08 To work in conjunction with community and practice based care management providers to avoid duplication of effort and services

2.16.09 To identify member strengths and preferences as well as risks which may affect the outcomes of the member

The Care Management program shall serve as a continuing resource to members as circumstances and needs change. Where possible, continuity in relationships with Care Managers shall be preserved by the Contractor, especially when a member has an established relationship with a practice and/or community case or care management provider such as a medical home, health home, or community health team.

2. CORE CARE MANAGEMENT PROGRAM COMPONENTS

The Care Management program will include the following core components:

2.18.09.01 Health Risk Assessment
2.18.09.02 Short Term Care Coordination
2.18.09.03 Intensive Care Management

2.1 Health Risk Assessment

A Health Risk Assessment shall be completed for all members through contact with the member or the member's family, guardian or adult caregiver. Contact can be either telephonic or in-person by a care manager or care coordinator from the Health Plan and/or from an accountable entity provider such as a medical home, health home or community health team. This screen is intended to identify adults and children with needs that call for further action within the Care Management program. As such, the Contractor shall assess and determine the need for a face to face encounter with the member as part of its process to engage the member in a care management program and/or other intervention or program as appropriate.

Purpose

The primary purpose of the Health Risk Assessment is to:

- Identify members who are at risk of poor outcomes and/or who may require more intensive care management activities.
- Identify immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying providers).

- To introduce members to the assistance provided by care management either by the Health Plan and /or an established provider or community care manager.
- Assist all members in improving health outcomes.
- Trigger next steps, where indicated.

On the basis of the Health Risk Assessment, it will be determined that an individual fits in one of the following categories:

- Health Maintenance Focus. This pertains to members who are not in current need of further assistance to meet current service delivery needs and do not need more comprehensive coordination or more intensive care management activities, but for whom maintenance of current health status, independence, and self-management, and prevention of further disability and/or chronic disease should be a priority. It may also identify those areas of strength, which if lost or altered could require the initiation of additional supports or services.
- Further Action Required. In such cases, potential needs have been identified and further follow up is indicated either with care coordination and/or Intensive Care Management (see descriptions of each below).

Scope

The Health Risk Assessment conducted by the Health Plan and/or its delegated accountable entity, medical home, health home, or community health team must identify adults who have transition of care needs and who may benefit from care management services:

- The Health Risk Assessment shall have an interdisciplinary, holistic, preventive health and strength-based focus, and screen for medical/physical needs, behavioral health needs, functional, social and financial issues with an aim of maximizing independence and functioning.
- The Screen shall identify and meet specific linguistic and cultural needs and address any barriers to care.
- The Screen must identify needs for continuity of care and assistance in securing appointments/procedures, prior authorizations, medications, hospitalizations, or other benefits; satisfaction with PCP selection; determination of current use of out-of-network providers; and current involvement with a specialist who may serve as a principal coordinating physician for that member.
- The Screen shall identify member's risk factors that may indicate potential need for care management. These must include but are not limited to:

- Perceived health status
- Behavioral health and substance use status
- Sense of being overwhelmed by their condition and how to navigate the health care system, inclusive of potential linguistic or social barriers
- Social determinants of care
- Medical status and history, including primary and secondary diagnosis, Health maintenance-preventive and chronic care management, and oral health
- Utilization of prescription medications
- Excess inpatient hospital, emergency EOHHS and prescription medication utilization that would indicate someone who is at high risk. Service use that is above that which would be considered usual or routine
- Complexity and intensity of care needs (e.g. related to acuity, duration, frequency of exacerbations and service needs, multiple diagnoses)
- Recognition of existing and potential formal and informal supports, including peer supports as well as caregiver burden
- Determination of willingness and capacity of family members or, where applicable, authorized persons and others to provide informal support
- Involvement or need for involvement with multiple providers, multiple therapies, other service systems (e.g. MHRH, DEA, etc.) and community agencies.
- Functional or environmental limitations or deficits, e.g. activities of daily living, mobility
- Stability of the home setting and ability of the member or their designee to process information, make decisions, coordinate services and advocate for themselves (e.g. related to resources, skills, time constraints, competing demands, health needs and problems of other family members
- Requirements for specialized therapies, medical supplies or DME
- Condition and proximity to services of current housing, and access to appropriate transportation
- Identification of current or potential long-term service needs
- Transitions from adolescence to adulthood
- Advance care planning

Timeliness

The contractor and shall in collaboration with delegated entity such as an accountable entity, medical home, health home or community health team conduct a Health Risk Assessment of new members who have not been enrolled in the prior twelve (12) month period. The Health Risk Assessment must be completed for all members within ninety - (90) days of the of the member's enrollment with the Contractor or within ninety (90) days of the member's twenty-first (21) birthday. In the initial start-up period, The Health Plan has one-hundred and eighty (180) days to conduct the Health Risk Assessment of members who become eligible at the beginning of the contract start-up period. The contractor shall make at minimum three outreach attempts to contact each member.

The contractor agrees to make all reasonable efforts to engage new members in person by telephone, mail, and/or on line to have the member complete the Health Risk Assessment. Health Risk Assessment completed by a provider or community case management within the last twelve (12) month can be utilized to inform the completion of the Health Risk Assessment.

Qualified Staff

Appropriately trained non-licensed or licensed personnel may perform Health Risk Assessment. Where performed by non-licensed personnel, the Health Plan shall establish appropriate qualifications requirements (including education, experience, and training) for these performing personnel to assure that these activities are effectively carried out; such activity shall be under the direct supervision and oversight of a Care Manager who meets the licensure requirements as set forth herein. Non-licensed or licensed personnel may perform Short Term Care Management activities. Members shall be offered assistance in arranging an initial visit to their provider for a baseline assessment and other preventive services, including an assessment of the member potential risk, if any, for specific disease or condition.

Health Risk Assessment

Purpose

The Health Risk Assessment has two primary purposes. The first is to determine specific needs for access to services and/or continuity of care that would dictate the content and objectives of care coordination; and/or the second is to determine the presence of risk factors for the member that would indicate the need for a more intensive care management.

Regarding coordination of services and continuity of care, the Health Risk Assessment will examine the circumstances of the member that need to be addressed from a care coordination perspective. These can include, for example: current involvement with a regimen of care for which prior authorization is required for continued service; difficulties in identifying or gaining access to specific types of providers to meet needs; support in transitioning from pediatric to adult health care; changes that have occurred or are occurring in independent living; changes in service arrangements with medical or non-medical services that may accompany the transition to adulthood; current involvements with an out of network provider and the need for arrangements to ensure continuity; dependence on medications or medical equipment or supplies.

Care Coordination is expected to require limited focused effort and consists of those actions necessary to work on behalf of members to address identified information needs and referrals, coordination of services, access and continuity of care needs.

Identification of risk: The Health Risk Assessment must differentiate between members for whom care coordination is sufficient and for whom a more intensive level of care management and support may be necessary to:

- Prevent detrimental change in the member's health status
- Maintain the member's ability to live in the community
- Avoid acute episodes of hospitalization or institutionalization

Cases where a more intensive level of review may be necessary can include:

- Members who have complex conditions that may require multiple services.
- Households where the caregivers have limited knowledge and ability to advocate for and facilitate the care for the member.
- Circumstances where the member is overwhelmed or is at risk of being overwhelmed by their circumstances and needs and face considerable difficulty self-managing their condition.

2.2 Intensive Care Management Plan

It is anticipated that for the majority of members moving beyond the Health Risk Assessment, care coordination will be sufficient. Where indicated or requested by the member or family, an Intensive Care Management plan is to be developed based on the Health Risk Assessment.

The Intensive Care Management Plan is a person driven plan developed for members at risk. It will be developed and ideally led by the member in collaboration with the member's provider (medical or behavioral health), the member's family, guardian or caregiver; home and community-based waiver provider or case worker, and other public and private providers and agencies if applicable. The Plan will include:

- Identification of key issues for the member as determined in the Health Risk Assessment.
- Identification of all medically necessary services and Health Plan actions appropriate to
- Prevent detrimental change in the condition(s) and to promote the development or maintenance of appropriate functioning by the member. This includes behavioral health services and social supports and services.
-
- Involve members and their families in setting goals, objectives, and action steps and identifying priorities to address member issues.
- Goals for the enrollee which include self-management, appropriate use of resources, ability to identify their own triggers and the ability to use the health care system effectively (e.g. keeping appointments)

Health Plans must identify out of plan items and services and take action appropriate to prevent decrement change in the member's condition(s) and to promote the development or maintenance of appropriate functioning by the member. Services include: behavioral health services; health education and social support services that are indicated for the member or a caregiver, and coordination with home and community-based waiver providers.

It is the preference of the EOHHS that this be accomplished in collaboration with medical homes, health homes, community health team and home and community-based waiver service provider, if applicable, to effectively coordinate care, identify roles and responsibilities and avoid duplication of services

Communication with member

The Health Plan must ensure that Intensive Care Management Plans, in the case of an enrolled adult upon request are promptly made available to the member, guardian, or adult caregiver. The Health Plan shall inform all members that they are entitled to request a written or electronic copy of the Intensive Care Management Plan.

3. ADDITIONAL REQUIREMENTS

3.1 Record Keeping Regarding Core Components of Care Management

The Health Plan shall maintain records to identify completion of Health Risk Assessment, care coordination, and Intensive Care Management. For all members receiving intensive care managements, records shall include the resulting Intensive Care Management Plan or documentation of why such a plan is not needed.

3.2 Designation of a Program Coordinator (Care Manager)

The Health Plan will designate a Program Coordinator (and/or Care Manager). The Care Manager will be a licensed professional who shall assure that the Health Risk Assessment, care coordination or Intensive Care Plan development and implementation, as indicated, are completed for each member. The Care Manager must meet the licensure requirements as set forth herein. The responsibilities of the Care Manager shall be inclusive of behavioral health services and social supports and services.

3.3 Continuing Care Management for Members and Families

Core Care Management components as described above are focused primarily on new adult enrollees. The Care Manager and care management staff shall also be a resource for members, their guardians, caretakers' and providers in accessing needed services and Care Management components as such needs arise during the course of enrollment with the Health Plan. Members and families are to be provided with written information as to how they can access the Health Plan's care management program at any time.

3.4 Health Plan Policies and Procedures

- The Health Plan shall have a written program description and Policies and Procedures that delineate compliance with these Care Management Protocols for members covered under his Agreement. The Health Plan's policies and procedures are subject to review and approval by the EOHHS. The following elements should be included in the Health Plan policies and procedures: Written description of the activities and responsibilities that are part of the care management process, including procedures for monitoring the coordination of care provided, including but not limited to medically necessary services delivered in and out of the Health Plan's provider network.

- Process of demonstrating shared decision making with the member, inclusive of member attestation or signature of a care management plan, if applicable.

- Annual review and evaluation of the program description with approval by the Health Plans' governing body or authorized designee.

- Process for obtaining input into the development of the Health Plan's care management program and annual evaluation, including input from members (and families/caregivers as appropriate with written or verbal consent) and providers.

- Process for completing Health Risk Assessments

- Process for review/approval of assessment tools by EOHHS.

- Standardized procedures/description/methodology for identifying members for care management, including a process for self-referral and regular review of utilization and claims data.

- Description of the qualifications of people who will act as care managers, the approach for having sufficient staff available/monitoring caseloads, and the appropriate methods for using a multi-disciplinary team.

- Description of the components of a care plan, including how it is developed and reviewed in collaboration with the members and other members of the members' care team.

- Process for collaborating with out-of-plan services, including but not limited to home and community based waiver programs.

- Process and standards for oversight of care management activities delegated to a subcontractor or delegated medical group (if applicable), inclusive of accountable entities and/or medical home, health home or community health team

- Process for obtaining member input on satisfaction with individual care manager services.

- Information systems to support monitoring/management of care plans, the care management program, communication, and information-sharing among care managers, providers, accountable entities, provider and community care managers

- Process to regularly update care plans based on changes in the member's medical or social status.

- Process to obtain information on recommendations made by nurses staffing after- hours advice line (if applicable)

3.5 Care Management Staff Based in Rhode Island

Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island and may be augmented by Health Plan expertise located in other areas. Rhode Island staff will be key for their ability to work closely with local resources and communities including face- to-face meetings where appropriate, to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs and out-of-plan services. The Contractor's Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island. Contractor should leverage existing provider and community based care management resources in performing care management program requirements to ensure no duplication, and may also delegate care management responsibilities to network providers including but not limited to patient-centered medical home providers, health homes and community health team. The contractor must operationalize the lead care management process as outlined below.

3.6 Modification to Rhode Island EOHHS Protocols for Members

EOHHS reserves the right to amend these Care Management protocols from time to time, with reasonable notice to Health Plans.

3.7 Additional Provisions for Special Population Groups

3.07.01 Provisions for Members who are Active with a Ryan White non--medical Case Management Agency

For those members whom are actively engaged with an AIDS Case Management Agency for non-medical case management, the Contractor shall develop policies and procedures that support the AIDS Case Management Agency as the lead care manager for that member. Contractor may employ predictive modeling tools to identify members who are newly infected with HIV, and develop protocols for referring and engaging them with an AIDS Case Management Agency.

3.07.02 Provisions for Members who are recently discharged from Corrections Facilities

Contractor may modify the Health Risk Assessment (HRA) to seek information regarding incarceration history. For those members for whom a history of incarceration is known, the Contractor may incorporate a record of data from the EOHHS of Correction's Electronic Medical System in the members file or in the care management system.

For those members for whom a history of incarceration is known, the Contractor shall coordinate with Reentry Council Agency to discuss and review the existing Plan of Care and new items identified during HRA. Contact with the Reentry Council Agency will take place within 30 days of notification to Contractor that the member is engaged with the Reentry Council Agency.

3.07.03 Other Special Populations

The Contractor and EOHHS will work collaboratively with stakeholders during the start-up period to develop specialized care management programs and level of care criteria to determine utilization review requirements for special populations. These special populations include but are not limited to:

- Children with Special Health Care Needs
- People living with HIV and AIDS
- People with serious mental illness
- People with addiction issues
- People recently discharged form correctional facilities

Prior to the development of the specialized care management programs, the Contractor shall coordinate services with the following providers and/or agencies:

- The RI EOHHS of Behavioral Health Developmental Disabilities and Hospitals (BHDDH)
- The RI EOHHS of Corrections
- AIDS Case Management Agencies

3.8 Planning for System Redesign and Transition

The Contractor will work collaboratively with EOHHS, BHDDH, and other stakeholders to integrate and transition behavioral health services into managed care.

Prior to the development of the specialized care management programs, the Contractor shall coordinate services with the RI EOHHS of Behavioral Health Developmental Disabilities and Hospitals (BHDDH) and its licensed providers.

ATTACHMENT R

COMMUNITIES OF CARE

ATTACHMENT R
COMMUNITIES OF CARE

1. OVERVIEW OF COMMUNITIES OF CARE

Under the terms of this Agreement, Contractor shall establish and maintain a Communities of Care (CoC) program as set forth in this Attachment. Program requirements will be further described in the Executive Office of Health & Human Services (EOHHS) Communities of Care Program Document.

Under the terms of this Agreement, Contractor shall comply with these "Rhode Island (RI) Executive Office of Health & Human Services Communities of Care (CoC) Requirements". Contractor shall establish Policies and Procedures to comply with these protocols. Contractor's Policies and Procedures are subject to review by the State. Contractor agrees to participate in a collaborative planning process with EOHHS and other Contractors to develop a pain management benefit for Medicaid managed care enrollees.

1.1 Goals

The primary goal of the CoC Initiative was to decrease non-emergent and avoidable Emergency Room (ER) utilization and associated costs for frequent ER utilizers through improved service coordination, defined member responsibilities and associated incentives and rewards. The Initiative also includes members who have two or more inpatient admissions within a specific period of time. These changes allow the Contractor the flexibility to get the right services, to the right people, in the right setting, and at the right time. The thrust of the Communities of Care Initiative is to reinforce care management and to provide incentive/rewards to members who are responsible and maintain good health practices in the CoC Initiative.

1.2 Identification for Enrollment in Communities of Care

The target populations for CoC are the Contractor's enrollees who have had three (3) or more ER visits or two (2) or more inpatient admissions in a twelve (12) month period. Contractor shall develop Policies and Procedures to continuously identify members eligible for CoC on a monthly basis.

1.3 Key Elements of the Communities of Care Initiative

Once identified as meeting the requirements for enrollment in CoC, the initiative will consist of the following core components:

- Step 1: Health Service Utilization Profile
- Step 2: Member Outreach and Engagement
- Step 3: Assignment to Pharmacy Home Program (i.e. "Lock-In") when warranted

- Step 4: Assessment for Care Management and/or Peer Navigator
- Step 5: Development and Implementation of Healthy Reward Component of CoC.

These components are more completely described in the later sections of this attachment.

1.4 Health Service Utilization Profile

Contractor shall establish Policies and Procedures to continuously identify CoC enrollees through several mechanisms: (1) utilization analysis of the Health Plans claims system, (2) identification from hospital ER reports, (3) provider referrals, and (4) other appropriate methods selected by the Contractor.

Once identified as a CoC eligible member, the Contractor shall have Policies and Procedures for using all available data sources to create a Health Service Utilization Profile for each member of the program and to make a preliminary determination as to the level/type of intervention appropriate for that member. This profile also will determine whether the member is currently enrolled in the Contractor's Care Management Program, if the member is receiving Primary Care at a Patient Centered Medical Home, Health Home, Community Health Team or another form of Enhanced Practice Site.

1.5 Program Enrollment/Program Completion

Enrollment in CoC commences upon identification as described in the Agreement of this Attachment. Completion of participation in CoC will occur when one of the following conditions are met:

- Loss of Medicaid eligibility
- Completion of 12-months in the CoC Program

The Contractor shall establish Policies and Procedures to review the utilization of former CoC members, at six-month and one-year post-discharge, to assess their current utilization of the ER.

2. PHARMACY HOME PROGRAM

Another component of the CoC program pertains to the Pharmacy Home program. The objective of the Pharmacy Home program is to prevent members from obtaining excessive quantities of prescribed medications through visits to multiple prescribers and pharmacies and improving health outcomes. Participants enrolled in the program are required to obtain all medications from a specific pharmacy location otherwise known as a Pharmacy Home for a period of two (2) years.

The Contractor will develop Policies and Procedures outlining the guidelines and process for identifying members who qualify for the program. All Policies and Procedures are subject to review by EOHHS. Members will be notified at least 30 days prior to enrollment in the program.

2.1 Identification for Pharmacy Home Program

The Contractor shall establish specific criteria to identify members for enrollment in the Pharmacy Home Program. The Contractor's Pharmacy Home criteria are subject to review and approval by EOHHS. Contractor will establish Policies and Procedures to identify CoC members for inclusion in the Pharmacy Home Program.

2.2 Select Provider Referrals

For CoC members with complex medical and/or behavioral health needs, Contractor shall ensure that members are connected with high quality select providers to meet those needs. Contractor shall identify select providers from within their existing Provider Network available to meet members' various health care needs. As needed, Contractor shall ensure facilitated referrals of members to appropriate providers. This is not intended to disrupt existing satisfactory patient-provider relationships. Rather it is to ensure that health care needs are being addressed in the most appropriate setting by qualified providers and in a coordinated fashion.

CoC members who use multiple providers and have one or more complex medical conditions and chronic diseases (e.g. diabetes, chronic obstructive pulmonary disorder, heart failure, asthma, generalized anxiety disorders, depression) shall be referred as needed to a select provider. The Contractor's Provider Networks shall contain and identify select providers, inclusive of pain management specialists who have experience serving the elderly, disabled adults, and those with chronic diseases and multiple complex medical conditions. The Contractor shall have Policies and Procedures for referral and follow-up of CoC members to select providers within their Provider Network.

3. CARE MANAGEMENT PROGRAM COMPONENTS

A major component of the CoC Initiative is the provision of enhanced Care Management. All members identified for enrollment in CoC shall be assessed for potential participation in intensive care management and the peer navigator program:

1. Medical and behavioral health oriented Care Management provided by a professionally trained Care Manager as described in ATTACHMENT Q to this Agreement.
2. Facilitation and mentoring provided by a Peer Navigator.

The Care Management component of CoC shall include the following core components:

- Outreach and Engagement, including completion of the CoC Emergency Room Survey focused on identifying the factors associated with the high level of ER utilization. This shall be completed either by or with the member. Completion of the Emergency Room Survey shall qualify the member for an incentive reward.

- Coordination with/referral to Contractor's established Care Management programs
- Coordination with/referral to Peer Navigator
- Development of Individualized Care Plan, to be developed in conjunction with enrollee by either the Care Manager or the Peer Navigator
- Coordination with care manager at physician/clinical site (e.g. CTC practices, Behavioral Health provider, Patient Centered Medical home (PCMH) practices, and community health teams)

3.1 Outreach and Engagement

For every member identified for enrollment in CoC, Contractor shall establish Policies and Procedures for outreaching to that member.

3.1.1 Purpose of the Outreach Activities

The primary purpose of this outreach will be to identify reasons why the member opts to utilize the Emergency Room for a non-emergent condition and/or has incurred inpatient hospital admissions and how that utilization can be avoided in the future. This includes both avoidance of unnecessary ER utilization and avoidable inpatient admissions and improved connections with care providers to help avoid acute episodes and improve management of chronic conditions. Outreach activities shall be key to determining the appropriate intervention for members. Contractor shall identify levels of intervention with CoC members based on their EOHHS approved program design. Levels of intervention might include:

- Strategies for identifying and targeting initiatives for sub-groups among high utilizers with distinct patterns of utilization and health services need
- Formal communications to all CoC members
- Member services based outreach and follow up to ensure member involvement with a medical home and/or behavioral health home
- Ensuring involvement of Care Manager, whether with Contractor or embedded within a Primary Care Home.
- Ensuring involvement of a Peer Navigator

3.1.2 Outreach Components

The Contractor shall discuss with the member the reasons for his/her ER use or inpatient admissions in order to identify potential gaps to better meet health needs. This shall include discussion of the role of the Primary Care and/or Behavioral Health Provider, if applicable, and community-based alternatives to the ER when he/she is not available. The Contractor will identify whether the member has a

"primary care home" and/or Health Home if the medical or behavioral health home has a Care Manager and/or Peer Navigator embedded in the practice. In addition, the Contractor shall review the CoC Initiative, and the member's responsibilities and rights related to enrollment in CoC.

3.1.3 Qualified Staff

Staff trained by licensed personnel, as described in the Agreement, may perform the initial outreach.

3.2 Coordination/Referral to Care Management

For those members identified for enrollment in CoC, Contractor shall have Policies and Procedures for identifying those members in need of care management and currently not connected with a care manager, either via the Contractor's Care Management Program or via the member's primary care medical home and/or behavioral health home. When appropriate, if a Care Manager has not been assigned and a Care Plan has not already been developed, the Contractor shall initiate the *Care Management Protocol* as described in ATTACHMENT Q. Where a care plan has been developed, it shall be re-assessed to incorporate the goals of CoC. This shall be done in collaboration with the member and the Peer Navigator. A structured Care Management program at a member's Primary Care and/or Behavioral Health Home (e.g. Patient-Centered Medical Home and/or community health team) can serve as a substitute to Contractor's Care Management program. The Contractor will ensure that an individualized Care Plan is developed for members receiving Care Management and that appropriate attention is placed on ER utilization patterns. The Contractor shall also ensure that there is on-going collaboration and information exchange between the Contractor's Care Management team and the existing Care Manager(s) within the members Primary Care and/or Behavioral Health Home.

3.3 Coordination/Referral to Peer Navigator

3.3.1 Purpose

The role of the Peer Navigator is to assist the CoC member in reducing barriers to care, to access medical, behavioral health, and non-medical resources and to assist the member throughout the care coordination and treatment process.

3.3.2 Scope

The scope of the Peer Navigator shall include but not be limited to:

- Assisting with development of Individualized Care/Action Plan and Incentive Reward Planning
- Making appointments for health care services

- Canceling scheduled appointments
- Assisting members with transportation and interpreter needs
- Following up with members and providers to assure that appointments are kept
- Rescheduling missed appointments
- Linking members to alternatives to ER use for non-emergency care, when needed
- Assisting members with accessing both formal and informal community-based support services such as child care, housing, employment, and social services
- Assisting members in dealing with non-medical emergencies and crises
- Assisting members in meeting care plan goals, objectives and activities
- Providing emotional support to members, when needed
- Serving as a role model and guiding the member to practice responsible behavior

The Care Manager shall collaborate with the Peer Navigator to develop the member's Care and/or Action Plan.

3.3.3 Qualified Staff

The Contractor will sub-contract with an organized advocacy organization providing Peer Navigation. The Peer Navigator may be a trained peer or paraprofessional. All CoC members should have access to a Peer Navigator, either on-site at their Medical and/or Behavioral Health Home or at another community-based organization affiliated with the Contractor. The Contractor shall have Policies and Procedures for collaborating with the State's identified and approved peer advocate organizations.

The Contractor will demonstrate compliance with this provision by providing copies of the executed contract(s) to the EOHHS for review.

4. HEALTHY REWARDS PROGRAM

"The goal of the Healthy Rewards (formerly called the Incentive program) is to promote member responsibility by ensuring a member's active participation in the Communities of Care (CoC) program and engagement with his/her Care Managers and/or Peer Navigators. Members

shall receive a reward for completing the Emergency Room (ER) Survey and for their active engagement in specific activities during the intervention period. The Health Plan may provide incentive awards using a person-centered approach that align incentives with member individual goals. Example include: meeting with a RIPIN navigator or provide home visit or completion of a clinical visit. The Health Plans may rely on member self-report of activity completion in order to provide rewards in a timely fashion. Health Rewards shall be limited to a $25.00 value per reward. Contractor will provide a description of their Healthy Rewards Program to EOHHS for annual review and approval.

Contractor shall establish Policies and Procedures for all elements of the Healthy Rewards Program and submit to EOHHS for review and approval.

A. Qualifying Events

Contractor shall issue Health Rewards gift cards to CoC members based on successful completion of Qualifying Events. Contractor shall determine successful completion.

Engagement with a care manager and/or peer navigator shall consist of a structured conversation of twenty minutes or more with a Care Manager or a Peer navigator. Such engagement may include focus on factors influencing emergency room utilization, other health services needs and additional circumstances (e.g. social/financial) that affect health utilization.

B. Timeliness of Issuing Gift Cards to CoC Members

Timely issuing of Healthy Rewards gift cards is an important part of this program. Healthy Rewards Gift Cards shall be issued to CoC members on the first and the fifteenth of each month to all persons completing a qualifying event during that period and in all cases no later than 12 (twelve) business days after the CoC member has accomplished the activity related to the reward.

C. Healthy Reward Operations Plan, Payment, Tracking and Reporting

The Contractor shall develop a Healthy Rewards Operations Plan and administer the Healthy Rewards, including, but not limited to the following activities: securing and obtaining the rewards; distributing the rewards to members; monitor the Healthy Rewards and the dispensing of the rewards; and reporting to the EOHHS information about member participation, the scope and magnitude of rewards, and the impact and cost of the Healthy Rewards.

Reconciliation between the EOHHS and the Contractor shall be conducted as part of routine reporting by Contractor. The Contractor shall track all qualified expenditures by category made for Healthy Rewards gift cards and report quarterly on the balance remaining from the two

lump sum payments in a format determined by the EOHHS. Qualified expenditures shall be defined as:

Qualified Expenditures for Healthy Rewards gift cards, including administrative expenses as set forth above, for:

- Qualified events
- Administrative expenses
- Qualified expenditures shall not include costs for Healthy Rewards gift cards that are returned as undeliverable mail.

The Healthy Rewards program is exempt from the risk sharing provisions contained in ATTACHMENT N of this Agreement between the EOHHS and the Contractor.

Additional programmatic/process reporting shall include but not be limited to the number of rewards issued in a certain time period to CoC members by stratification group, the number of rewards redeemed in a certain time period, compliance with contractual timeframes for issuing rewards, and other data elements to be determined by the EOHHS."

5. TIME LINES

Contractor shall submit its' Outreach Plan to EOHHS for review and approval annually.

For each month's cohort of CoC enrollees, Contractor must complete the following in the first thirty (30) days:

- Complete Utilization Profile
- Assign designated enrollees to the Pharmacy Home Program, if applicable Initiate Outreach and Engagement and refer enrollees to Care Managers and/or Peer Navigators

By day sixty (60) the Contractor will develop for each CoC enrollee an Individualized Care and/or Action Plan that addresses members' ER utilization patterns and administer Rewards as appropriate.

For enrollees identified for CoC on the first day of each month subsequent to the start date of this Agreement, Contractor shall complete the Health Service Utilization Profile, initial Outreach and Referral to Case Management and/or Peer Navigation as outlined above. For CoC designated members, Contractor shall complete the development of a CoC Care/Action Plan that addresses the individual's ER utilization patterns and administer Reward Planning as outlined above.

6. IMPLEMENTATION

The Contractor shall implement CoC upon the effective contract date and maintain the CoC Initiative throughout the contract period, unless notified by EOHHS.

EOHHS reserves the right to conduct readiness reviews of Contractor to assure a proper and timely implementation of the CoC Initiative. The capitation rates contained in ATTACHMENT J of the contract identify both the medical portion and the administrative portion of the capitation rates for each premium cell. The capitation includes an adjustment to the administrative portion of the rate for the CoC. The PMPM value of that adjustment is identified in the Data Book. In the event of an EOHHS approved CoC program, Contractor capitation payments will include that adjustment.

7. MODIFICATION TO RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES COMMUNITIES OF CARE PROTOCOLS

The State reserves the right to amend the Executive Office of Health and Human Services (EOHHS) CoC Program Document from time to time, with reasonable notice to Health Plans.

8. INTEGRATED PAIN MANAGEMENT PROGRAM FOR COMMUNITIES OF CARE MEMBERS

8.1 Statement of Intent

The experience of pain is often the reason for utilization of health care resources, including costly emergency department visits. Optimal management of chronic pain will enable individuals enrolled in Communities of Care (CoC) to achieve more productive lives, improve their quality of life, and decrease the utilization of scarce medical resources and the associated costs.

The principles that shall guide the development of Contractor's pain management program include:

1.01 Patient oriented care that focuses on the whole person (i.e. mind, body and spirit) Employment of evidenced-based clinical practice guidelines, as applicable

1.02 Creation and utilization of an integrated treatment plan that coordinates all appropriate therapeutic approaches and care by health professionals

1.03 Integration of alternative therapies (e.g. chiropractic care, osteopathic manipulation, acupuncture, therapeutic massage) when diagnostically appropriate for individual patients

1.04 Care provided fosters close and ongoing collaboration with Primary Care Providers

Eligibility for participation in the pain management program is limited to the subset of Communities of Care (CoC) members who have diagnoses of chronic pain, and demonstrate

a readiness for program participation. A member demonstrates their readiness for program participation by completing a care plan with the holistic nurse. Chronic pain diagnoses include but are not limited to chronic neck pain, chronic back pain, migraine, and fibromyalgia. The Contractor shall identify CoC members eligible for the pain management program using a predictive modeling algorithm reviewed and approved by EOHHS. CoC members participating in the pain management program will receive services from a holistic nurse, and will also be eligible to receive complementary alternative medicine (CAM) services, as authorized by the Contractor. CAM services will be subject to the benefit limits described in Section 8.6 of ATTACHMENT R. Payment for services will be subject to the conditions described in ATTACHMENT R Section 8.9.8.

A holistic nurse is defined as a licensed registered nurse (RN) with appropriate training in pain management techniques including but not limited to health coaching, motivational interviewing, and chronic disease management.

The Contractor may enter into written subcontract(s) for performance of certain of its contract responsibilities listed in this Amendment. All subcontractor arrangements are subject to the conditions defined in Section 3.05.05 of this Agreement.

8.2 Identification

Contractor shall identify all CoC members eligible for the pain management program using a standardized algorithm, on a monthly basis. Contractor shall reserve the right to refer additional CoC members to the pain management program who are not identified by the algorithm. Contractor reserves the right to exclude members from the program.

A member is considered enrolled in the program once they have been engaged by a holistic nurse and an assessment and care plan is completed. The member will remain enrolled in the program until such time as the member's CoC enrollment is ended, or the member loses eligibility for Medicaid. Members who lose Medicaid eligibility and re-enroll with the Contractor, may be re-enrolled in the pain management program upon their re-enrollment.

Those members who are referred and not engaged by the holistic nurse, despite ongoing attempts, for a minimum of three (3) months or other timeframe at the discretion of the Contractor, will be dis-enrolled from the program by the Contractor.

The Contractor may dis-enroll a member for non-compliance. Members may voluntarily dis enroll from the program at any time by contacting their holistic nurse. Disenrollment are effective on the day the voluntary disenrollment was requested.

The Contractor may not dis-enroll a member from the pain management program because of an adverse change in the members' health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment in the program seriously impairs the Contractor's ability to furnish services to this member or other members.

8.3 Stratification

Contractor will stratify the population referred to the pain management program. This stratification will assist in the prioritization of outreach and will assist in the development of the individualized care plan.

8.4 Outreach and Assessment

An Initial Assessment shall be completed for all CoC members referred to the pain management program. Through contact with the member or the member's family, guardian or adult caregiver, the Contractor will administer an assessment. Contact can be either telephonic or in-person. This assessment is intended to assess the needs that call for further action within the pain management program, as well as readiness to address the root cause of the pain or other co-occurring disorders. The assessment tool will be reviewed and approved by EOHHS.

This assessment will measure several areas related to pain management including:

- Functional health and well-being
- Ability to perform routine daily tasks
- Perceived health status
- Depression and anxiety
- Other mental health issues or conditions
- Substance use
- Effect of pain on social interactions

8.4.1 Time frames for Outreach and Assessment

For members with a CoC start date on or after April 1, 2012, the Initial Assessment must be completed within forty-five (45) days of the member's referral to the pain management program. Contractor shall make several attempts to contact referred CoC members over several weeks.

For members with a CoC start date on or after October 1, 2011, but before April 1, 2012, the Initial Assessment must be completed within one hundred and twenty (120) days of the member's referral to the pain management program. Contractor shall make several attempts to engage referred CoC members over several weeks.

After the Initial Assessment is completed, assessments will be repeated on a schedule determined by the Contractor, but no less frequently than at 6 months and 12 months, as appropriate, to determine progress.

8.4.2 Qualified Staff

Appropriately trained and licensed registered nurses shall perform the Initial Assessment. Holistic nurses working with CoC members in the pain management program will receive training in health coaching, motivational interviewing, and chronic disease management.

8.5 Holistic Nurse Services and Care Plan Development

Once outreach and assessment is complete, the Contractor will determine whether the CoC member has a readiness level to engage in the program.

Holistic nurses shall integrate and coordinate care throughout the pain management program. The holistic nurse shall also serve to coordinate referrals to appropriate practitioners and provide explanations regarding holistic and allopathic interventions the patient will be receiving in a manner that will be easily understood by the enrolled and managed members. The pain management program shall include coordination of care rendered by primary care providers, specialists and practitioners of complementary/ alternative medicine, and traditional ancillary service providers currently enrolled in the Contractor's network, as well as, acupuncturists, licensed massage therapists, and other providers identified as effective in the management of the identified disease states. Coordination of integrated therapies services shall be provided by a team composed of the beneficiary's physician, registered nurses (RN), and other licensed/certified health care providers (chiropractors, acupuncturists, and massage therapists) working in conjunction with the member's primary care case manager and other health care providers. Components of the clinical service delivery will focus on decision support for the patient's physician(s) and supported self-care for the member.

Contractor shall develop a process for integrating the pain management program into the larger CoC program or other relevant care management programs (e.g. behavioral health).

Contractor shall develop a process for collaboration with any qualified Health Homes, with the intent to avoid duplication of services.

For members with a readiness level to engage, a plan of care will be developed with the member and the holistic nurse. The Care Plan will include:

- Identification of key issues for the member as detem lined in the Assessment

- Identification of all medically necessary services and Health Plan actions appropriate to prevent decrement change in the condition(s) and to promote the development or maintenance of appropriate functioning by the member. This includes behavioral health services.
- Involve member in setting goals, objectives, and action steps and identifying priorities to address member issues.
- Coordination with other covered services, as appropriate, including but not limited to behavioral health care, and nutrition services.
- Goals for the enrollee which include self-management, appropriate use of resources, ability to identify their own triggers and the ability to use the health care system effectively (e.g. keeping appointments)
- Expectations for the frequency of engagement between the holistic nurse and the members. The frequency of the holistic nurse interventions shall be based on the member's risk level. Those enrollees who are not engaged with a holistic nurse or are not receiving a CAM service for 3 consecutive months, shall be dis enrolled from the program.
- Expectations for the frequency of wellness education and other similar interventions.
- Frequency of utilization of the complementary alternative medicine services (i.e. chiropractic, acupuncture and therapeutic massage).

The plan of earn will be shared with the member's primary care provider and primary behavioral health provider as appropriate. The Contractor shall develop policies and procedures for tlle approval and denial of CAM services, consistent with state regulations.

During the initial assessment and stratification, the holistic nurse must attempt to identify risk factors that can be decreased through behavioral changes, *i.e.,* poor diet, lack of exercise, anger problems and coping difficulties or through coordination with care management and behavioral health. Targeted literature associated with minimizing risk factors must be distributed to patients by mail. Patient assessment indicating risk factors must be forwarded to the primary care provider and treating practitioners for coordination of care across disciplines.

The Contractor must ensure that plan of care is made available to the member, guardian, or adult caregiver, as appropriate upon request.

8.5.1 Time frames for Care Plan Development

The Plan of Care must be completed within thirty (30) days of the of the member's completion of the initial assessment.

8.5.2 Qualified Staff

Appropriately trained and licensed registered nurses will create and manage the plan of care. Holistic nurses working with CoC members in the pain management program will receive training in health coaching, motivational interviewing, and chronic disease management.

Contractor shall maintain a holistic nurse to member ratio that shall not exceed 1:175. Contractors shall require holistic nurses to collaborate and coordinate with Contractor staff and any other Subcontractor staff, in all areas of the program including but not limited to nurse care management, behavioral health care management, member services, provider services, quality assurance and medical management.

8.6 Coverage of Complementary Alternative Medicine Services

For certain CoC members, the Contractor is authorized, pending approval from the Centers for Medicare and Medicaid Services (CMS), to create a plan of care inclusive of the use of Complementary Alternative Medicine (CAM) Services. These CAM services are defined as treatment from a chiropractor, acupuncturist, and massage therapist. Use of the CAM providers as part of the plan of care must be determined by the Contractor to be clinically effective to produce the desired health outcome.

CAM services will be subject to certain annual benefit limits. Eligible members can receive up to forty-eight (48) encounters with CAM providers, in a twelve-month period.

8.7 Network Requirements for Complementary Alternative Medicine Services

Contractor will establish and maintain a geographic network designed to accomplisl1 the following goals: (1) offer an appropriate range of CAM services, for the anticipated number of enrollees in the services area; (2) maintain CAM providers in sufficient number, mix, and geographic area; and (3) make available all CAM services in a timely manner. Contractor agrees to make a CAM provider available to every member enrolled in the Pain Management Program within thirty (30) days of referral for CAM services.

All network providers must be credentialed in a manner consistent with the National Committee for Quality Assurance (NCQA), as well as consistent with any state of Rhode Island Rules and Regulations.

Contractor agrees to maintain and monitor a network of appropriate CAM providers that is supported by written agreements and can sufficiently demonstrate to the EOHHS's satisfaction, the Contractor's ability to provide CAM Services under this Agreement.

8.8 Reporting Requirements

Contractor agrees to provide EOHHS with uniform operational, programmatic and financial reports on a regular basis, and additional data in a manner acceptable to EOHHS. The format of these reports will be mutually agreed upon by the parties, and approved by

EOHHS. The frequency of these reports shall be a minimum of quarterly. This reporting shall include encounter data for CAM services.

8.9 Other Requirements

Holistic nurse services are to be performed by Contractor staff or agents located in the State of Rhode Island and may be augmented by Health Plan expertise located in other areas. Rhode Island staff will be key for their ability to work closely with local resources and communities including face-to-face meetings where appropriate, to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs and social supports.

The Contractor shall maintain records to identify completion of initial Assessment and Plan of Care.

EOHHS reserves the right to amend these protocols from time to time, with reasonable notice to Health Plans.

8.9.1 Quality Management. The Contractor agrees to incorporate the pain management program into the existing Quality Management infrastructure.

8.9.2 Education Materials. The Contractor shall maintain an education plan for enrolled beneficiaries and their primary care providers. The Contractor shall provide educational materials to the chiropractors, acupuncturists, and massage therapists participating in the project in order for patients managed by the program to receive ongoing education about disease processes and self-management. The Contractor shall submit the education materials in appropriate reading level, including the member and provider education plan as described below to EOHHS prior to contract execution for review and approval. The Contractor must comply with Section 2.05 of the agreement, related to content, reading level, review and approval of member materials.

8.9.3 Provider Orientation. The provider orientation plan must include the scheduling of in-service training sessions which will include a review of the components of the integrative therapies pilot, program introduction, best practices protocols and scenarios, documentation requirements and collaborative communication techniques.

8.9.4 Collaboration with other Providers. The Contractor will solicit the cooperation of primary care providers (PCPs) and specialty providers in the provision of the pain management program. The Contractor will send information regarding the pain management

program to the identified providers, both primary care physicians and specialists. The Contractor will be responsible for contacting these providers and enlisting their support to encourage enrollment of any eligible patients assigned to them into the program.

8.9.5 Program Staffing. The Contractor shall have a primary point of contact in place for the pain management program, serving as a program manager. In addition, the Contractor shall have the appropriate number of holistic nurse full time equivalents to manage a caseload of 1: 175.

8.9.6 Ongoing Monitoring and Oversight. EOHHS and the Contractor shall jointly monitor and oversee the Pain Management Program. This oversight function will include but will not be limited to meetings of EOHHS and the Contractor. The Contractor shall monitor the program with a specified set of metrics, approved by EOHHS. The Contractor shall also participate with EOHHS in an evaluation of the program.

8.9.7 Complaints, Grievances, and Appeals. Contractor shall maintain a Grievance System in accordance with Section 2.14 of the September 1, 2010 Agreement. All complaints, grievances and appeals shall be reported to EOHHS on a regular basis in a method approved by EOHHS.

8.9.8 Payment Method. Contractor shall be responsible for provider payments for services rendered as part of the pain management program. If Contractor subcontracts the responsibilities under this section, specific payment provisions will be reflected in the agreement with the subcontractor. All subcontractor agreements are subject to review by EOHHS.

Payments for services shall be allowable as a medical expense, as defined in ATTACHMENT N of the Agreement. The Contractor shall reserve the right to recoup fees that were inappropriately paid to a Subcontractor. Such situations may include, but not be limited to payment of fees for members inappropriately deemed eligible for participation by a Subcontractor, or payment of fees for members who a Subcontractor did not appropriately dis-enroll.

8.10 Health Plan Policies and Procedures

The Contractor shall have a written program description and Policies and Procedures that

delineate compliance with Integrated Pain Managed Program for CoC members. The Contractor's policies and procedures are subject to review and approval by EOHHS. The following elements should be included in the Contractor policies and procedures:

- Written description of the activities and responsibilities that are part of the holistic nurse services including procedures for monitoring the services provided, including but not limited to CAM services
- Annual review and evaluation of the program description with approval by the Contractor's governing body or authorized designee
- Process for completing initial assessment
- Process for review/approval of screening tools by EOHHS
- Standardized procedures/description/methodology for identifying CoC members for the integrated pain management program including a process for alternative referrals and regular review of utilization data
- Description of the qualifications of people who will act as holistic nurses, the approach for having sufficient staff available/monitoring caseloads, and the appropriate methods for using a multi-disciplinary team
- Description of the components of a care plan, including how it is developed and reviewed
- Process and standards for oversight of holistic nurse activities delegated to a subcontractor or delegated medical group (if applicable)
- Process for obtaining member input on satisfaction with individual holistic nurse services
- Information systems to support monitoring/management of care plans, the holistic nurse services, communication, and information-sharing among holistic nurses and providers
- Process to regularly update care plans based on changes in the member's medical or social status.

ATTACHMENT T

REPORTING CALENDAR

Medical and Behavorial Health Reporting Calendar

Health Plan Name Medical/Behavorial 2017	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Contacts
837 Processing Report 4	X	X	X	X	X	X	X	X	X	X	X	X	
Adult Behavioral Health Claims Report 4	X	X	X	X	X	X	X	X	X	X	X	X	
AE Attributed Lives Report 1	X			X			X			X			
AE Population Attribution Extract 4	X	X	X	X	X	X	X	X	X	X	X	X	
Annual Compliance Plan (Med & BH) 3												X	
APM Data Reporting 1	X			X			X			X			
Annual Quality Plan and Evaluation(Med & BH) 3					X								
Audited Financial Statements with notes					X								
CAHPS							X						
Children's Behavioral Health Claims Report 4	X	X	X	X	X	X	X	X	X	X	X	X	
Communities of Care 1	X			X			X			X			
Drug Utilization Data 1	X			X			X			X			
Drug Utilization Review Program	X												
Drug Utilization Review Program Activities	X												
Encounter Data	X	X	X	X	X	X	X	X	X	X	X	X	
Genetics First 1	X			X			X			X			
Grievance & Appeals 1	X			X			X			X			
HEDIS							X						
Hep C Treatment Report (Tracker) 2	X	X	X	X	X	X	X	X	X	X	X	X	
ID Cards/Member Handbooks 1	X			X			X			X			
Inf. Complaints 1	X			X			X			X			
MCO Monthly Planning HEDIS Use 4	X	X	X	X	X	X	X	X	X	X	X	X	
MCO Program Integrity Quarterly Report 1	X			X			X			X			
Member Fraud/Out of State Report 4	X	X	X	X	X	X	X	X	X	X	X	X	
Monthly Financial Statements 4	X	X	X	X	X	X	X	X	X	X	X	X	
NMC Annual Filing			X										
NMC Quarterly Reports 1	X			X			X			X			
Newborn File 4	X	X	X	X	X	X	X	X	X	X	X	X	
Pain Management 1	X			X			X			X			
Pediatric Physican Enhanced Rate 1	X			X			X			X			
PCP Reporting 1	X			X			X			X			
Pharmacy Committee Hep C Report 4	X	X	X	X	X	X	X	X	X	X	X	X	
Pharmacy Home 1	X			X			X			X			
Provider Panel Report 1	X			X			X			X			
Provider Snapshot Access Survey Results 1	X			X			X			X			
QIP/Performance Improvement Project 1	X			X			X			X			
Risk Share/Gain Share Report -Includes Accountable Entity Shared Savings) 2	X	X	X	X	X	X	X	X	X	X	X	X	
Stop Loss/ Slow Rite Care 4	X	X	X	X	X	X	X	X	X	X	X	X	
Subrogation 1	X			X			X			X			
SUD Residential Treatment 4	X	X	X	X	X	X	X	X	X	X	X	X	
Third Party Liability 1	X			X			X			X			
Utilization Reporting 1 (including high utilizers)	X			X			X			X			
Value Based Reporting 1	X			X			X			X			
	NOTE: These reports are required to be generated for all lines of business for medical and BH services as well as for any subcontractor providing services to your members.												
In addition to listed contacts please send all reports to:													
1 Due the last Monday of the month for previous month													
2 Due 45 days post the close of the reporting period													
3 Due 30 days post contract effective date, then annually thereafter													
4 Due by the last business day of the month for previous month													

ATTACHMENT U

CLAIMS BASED DATA ELEMENTS

CLAIM BASED DATA ELEMENTS		
Field name/Description	**Source/field number**	
MEMBER FIELDS	**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
CLAIMS FIELDS	1500	UB-04
Payer Authorization ID	Box 23	
Date of Service	Box 24A	Box 45
Admission Date	Box 18	Box 12
Discharge Date	Box 18	Box 6
From Date	Box 24A	Box 6
Thru Date	Box 24A	Box 6
Effective Date	Box 24A	
Line Number/ Line ID	Box 24A	
Line From Date	Box 24A	
Line Thru Date		
Facility Type		Box 4
Outpatient Type		Box 4
Admission Flag		Box 66A
Readmission Flag		
Admission Type		Box 14
Revenue Code		Box 42
Type of Bill		Box 4
Facility Name	Box 32	Box 1
Provider NPI	Box 32 A	Box 56
Provider Name		Box 01
CPT Code(s)	Box 24D	Box 74a-e
Modifier Code(s)	Box 24D	
HCPCS Codes	Box 24D	
HCPCS Modifiers	Box 24D	
DRG Code		Box 71
DRG Description	other	other

DRG Code Type {MS|AP|APR}	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	**other**	
Member Year		
Member Month {1..12}		
PCP last name		
PCP first name		
PCP NPI		
Member Risk Score		
RX FIELDS	other	
Drug Class		
Drug Name		
NDC Code		
Drug Type {Generic|Brand|Specialty|Other}		
Dispense as Written Code		
Days Supply		
Quantity Dispensed		
Therapeutic Class		
Filled Date		

INDEX

State Guide to CMS Criteria for Managed Care Contract Review and Approval

[i] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. C. Beneficiary Notification C.9 Marketing C.9.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from distributing marketing materials without first obtaining state approval. [1932(d)(2)(A)(I); 42 CFR 438.104(b)(1)(i)] C.9.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies how the MCE assures the State agency that its marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or State agency. [42 CFR 438.104(b)(2)] C.9.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's materials cannot contain any assertion or statement (whether written or oral) that the recipient must enroll in the MCE in order to obtain benefits or

in order to not lose benefits. [42 CFR 438.104(b)(2)(i)] C.9.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's materials cannot contain any assertion or statement (whether written or oral) that CMS, the Federal or State government, or a similar entity endorses the MCE. [42 CFR 438.104(b)(2)(ii)] C.9.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to distribute marketing materials to its entire service area as indicated in the contract. [1932(d)(2)(B); 42 CFR 438.104(b)(1)(ii)] C.9.6 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that the MCE does not seek to influence enrollment in conjunction with the sale or offering of any private insurance. [1932(d)(2)(C); 42 CFR 438.104(b)(1)(iv)] C.9.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities. [42 CFR 438.104(b)(1)(v)]

[ii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. D. MCE Policies, Procedures, and Systems F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d)(2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c)(1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d)(2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[iii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. B. Enrollment and Disenrollment B.1. No Discrimination B.1.1. [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to accept new enrollment from individuals in the order in which they apply without restriction up to the limits set under the contract. [42 CFR 438.6 (d)(1)] B.1.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from discriminating against individuals eligible to enroll on the basis of health status or need for health care services. [42 CFR 438.6 (d) (3) and (4)] B.1.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from discriminating against, or using any policy or practice that has the effect of discriminating against, individuals eligible to enroll on the basis of race, color, or national origin. [42 CFR 438.6 (d) (3) and (4)] B.2 Choice of Doctor B.2.2. [Applies to MCO, PIHP, PAHP] The contract requires the MCE to allow each enrollee to choose his or her health professional to the extent possible and appropriate. [42 CFR 438.6(m)] B.3 Opt Out B.3.1. [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies procedures for enrollment and reenrollment. [42 CFR 438.6 (d)(2)] B.3.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that MCE enrollment is voluntary, except when CMS has approved federal authority allowing the state to mandate enrollment. [42 CFR 438.6 (d)(2)] B.6 Disenrollment Request Process B.6.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCE files the request. [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.6(k); 42 CFR 438.56(c)] B.6.4. [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that if the entity or State agency (whichever is responsible) fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the enrollee or the MCE files the request), the disenrollment is considered approved. [42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(3)(ii); 42 CFR 438.6(k); 42 CFR 438.56(c)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. C. Beneficiary Notification C.2 Enrollee Information C.2.17 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide adult enrollees with written information on advance directives polices, and include: (1) a description of applicable State law, (2) the MCE's advance directives policies, including a description of any limitations the MCE places on the implementation of advance directives as a matter of conscience, and (3) instructions that complaints concerning noncompliance with advance directives requirements may be filed with the state Survey & Certification agency. [42 CFR 438.6(i)(3); 42 CFR 438.6(i)(4); 42 CFR 438.10(g)(2); 42 CFR 438.10(h)(2)] C.2.18 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to reflect changes in State law in its written advance directives information as soon as possible, but no later than 90 days after the effective date of the change. [42 CFR 438.6(i)(4)] C.4 Passive Enrollment C.4.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies any procedures for Passive Enrollment including timelines associated with any "trial period" (where applicable). The contract specifies how the MCE ensures that enrollees are adequately notified of their enrollment. [42 CFR 438.6 (d) (2)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)] D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100] D.1.5 [Applies to PAHP] The contract requires that the MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the PAHP if the MCE's provider network includes: home health agencies, home health care providers, personal care providers or hospice providers. [42 CFR 438.6(i)(2); 42 CFR 438.10(h)] D.13 Provider Preventable Conditions D.13.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to report all identified provider-preventable conditions in a form or frequency, which may be specified by the State. [42 CFR 438.6(f)(2)(ii)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.1 Network Adequacy E.1.1 [Applies to PCCM] The contract requires the MCE to provide reasonable hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions. [42 CFR 438.6(k)] E.1.2 [Applies to PCCM] The contract requires the MCE to make arrangements with or referrals to, a sufficient number of physicians and other practitioners to ensure that the enrollees are getting the services provided for under the contract, promptly and without compromising the quality of care. [42 CFR 438.6(k)(3)] E.1.11 [Applies to PCCM] The contract restricts enrollment to recipients who reside sufficiently near one of the PCCM provider sites to reach that site within a reasonable time using available and affordable modes of transportation. [42 CFR 438.6(k)] E.7 Balance Billing E.7.1 [Applies to MCO, PIHP, PAHP] The contract obligates the MCE to require that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers). [1932(b)(6); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.230(c)] E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)] F.11.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies that the MCE must require all providers to report provider-preventable conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made. [42 CFR 438.6(f)(2)(ii); 42 CFR 434.6(a)(12)(ii)] F.14 Enhanced Payments for Primary Care Services F.14.1 [Applies to MCO, PIHP, PAHP] For calendar years (CY) 2013 and 2014 the contract requires the MCE to make enhanced payments for primary care services delivered by, or under the supervision of, a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.400(a); Increased Payment to PCPs Q&A] F.14.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to base enhanced primary care payments on the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the CY 2009 Medicare physician fee schedule conversion factor. If no applicable

rate is established by Medicare, the MCE uses the rate specified in a fee schedule established by CMS. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405; Increased Payment to PCPs Q&A] F.14.3 [Applies to MCO, PIHP, PAHP] The contract stipulates that the MCE make enhanced primary care payments for all Medicaid- covered Evaluation and Management (E&M) billing codes 99201 through 99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, or their successor codes. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405(c); Increased Payment to PCPs Q&A] F.14.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide documentation to the state, sufficient to enable the state and CMS to ensure that primary care enhanced payments were made to network providers. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(B); Increased Payment to PCPs Q&A] F.17 EHR Incentive Payments F.17.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse electronic health records (EHR) incentive payments to eligible professionals, the contract establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate, in accordance with 42 CFR 438.6 c)(5)(iii). [1903(t); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.304; 42 CFR 495.310(c); 42 CFR 447.253(e); 42 CFR 495.370(a); SMD# 09-006, Attachment A] F.17.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates any of its responsibilities for administering EHR incentive payments to the MCE, the contract should describe the delegated activities. [42 CFR 438.6(c)(4)(ii)(A); Page 44514, Medicare and Medicaid Programs: Electronic Health Care Incentive Program: Final Rule, July 28, 2010]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.1 Inspection J.1.1 [Applies to MCO, PIHP, PAHP] The risk contract requires that the State agency and Department of Health and Human Services are allowed to inspect and audit any financial records of the MCE or its subcontractors. [42 CFR 438.6(g)] J.2 Compliance with State and Federal Laws J.2.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with all applicable Federal and State laws and regulations including: (1) Title VI of the Civil Rights Act of 1964 (2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities) (3) The Age Discrimination Act of 1975 (4) The Rehabilitation Act of 1973 - The Americans with Disabilities Act. [42 CFR 438.6(f)(1); 42 CFR 438.100(d)] J.2.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with applicable Federal and State laws regarding privacy and confidentiality. [42 CFR 438.6(f)(1); 42 CFR 438.100(d); 42 CFR 438.100(d)] J.4 Subcontracts J.4.4 [Applies to MCO, PIHP, PAHP] The MCE contract requires subcontracts entered into by the MCE to comply with any 42 CFR 438 requirements that pertain to the service or activity performed by the subcontractor. [42 CFR 438.6(l)] J.9 Insolvency J.9.3 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state or MCE does not pay the provider that furnishes the service under a contractual, referral, or other arrangement. [42 CFR 438.106(b)(2); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)] J.9.4 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCE provided the services directly. [42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)]

[iv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. E. Providers and Provider Network E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

[v] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. C. Beneficiary Notification C.1 Timing for the Provision of Enrollee Information C.1.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to notify all enrollees of their right to request and obtain the information described in the "Enrollee Information" section of this review tool at least once a year. [42 CFR 438.10(f)(2)] C.1.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide each of its enrollees all of the information described in the "Enrollee Information" section of this review tool within a reasonable time after the MCE receives notice of the recipient's enrollment from the State or its contracted representative. [42 CFR 438.10(f)(3)] C.1.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to give each enrollee written notice of any significant change in the information described in the "Enrollee Information" section of this review tool at least 30 days before the intended effective date of the change. [42 CFR 438.10(f)(4)] C.2 Enrollee Information C.2.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs and PAHPs, this includes, at a minimum, information on primary care physicians, specialists, and hospitals. [42 CFR 438.10(f)(6)(i)] C.2.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on any restrictions on the enrollee's freedom of choice among network providers. [42 CFR 438.10(f)(6)(ii)] C.2.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be treated with respect and with due consideration for their dignity and privacy. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(ii)] C.2.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.10(f)(6)(iii);

42 CFR 438.100(b)(2)(iii)] C.2.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to participate in decisions regarding their health care, including the right to refuse treatment. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iv)] C.2.6 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be free from any form of restraint or seclusion. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(v)] C.2.7 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to request and receive a copy of their medical records and request that they be amended or corrected. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(vi)] C.2.8 [Applies to MCO, PIHP, PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to obtain available and accessible health care services covered under the MCE contract. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(3)] C.2.9 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. [42 CFR 438.10(f)(6)(v)] C.2.11 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on procedures for obtaining benefits, including authorization requirements. [42 CFR 438.10(f)(6)(vi)] C.2.12 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers. [42 CFR 438.10(f)(6)(vii)] C.2.13 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the extent to which, and how, after-hours and emergency coverage are provided. This information must include at least the information described below. [42 CFR 438.10(f)(6)(viii)] C.2.14 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider. [42 CFR 438.10(f)(6)(x)] C.2.15 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on cost sharing, if any. [42 CFR 438.10(f)(6)(xi)] C.2.16 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on how and where to access any benefits that are available under the State Plan but are not covered under the contract, including cost sharing and how transportation is provided. [42 CFR 438.10(f)(6)(xii)] C.2.17 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide adult enrollees with written information on advance directives polices, and include: (1) a description of applicable State law, (2) the MCE's advance directives policies, including a description of any limitations the MCE places on the implementation of advance directives as a matter of conscience, and (3) instructions that complaints concerning noncompliance with advance directives requirements may be filed with the state Survey & Certification agency. [42 CFR 438.6(i)(3); 42 CFR 438.6(i)(4); 42 CFR 438.10(g)(2); 42 CFR 438.10(h)(2)] C.2.19 [Applies to MCO, PIHP] If the state delegates this function, the contract requires the MCE to provide state-developed or state- approved information to enrollees on grievance, appeal and state fair hearing procedures and timeframes. This description must include at least the following: (1) Enrollees' right to a state fair hearing, (2) The method for obtaining a hearing, (3) The rules that govern representation at the hearing, (4) Enrollees' right to file grievances and appeals, (5) The requirements and timeframes for filing a grievance or appeal, (6) The availability of assistance for filing a grievance, appeal, or state fair hearing, (7) The toll free number the enrollee can use to file a grievance or appeal by phone, (8) The fact that benefits will continue, when requested by the enrollee, if the enrollee files a timely appeal or state fair hearing request, (9) The fact that the enrollee may be required to pay the cost of the continued services furnished while the appeal is pending if the final decision is adverse to the enrollee, (10) Any appeal rights the state makes available to providers to challenge the failure of the organization to cover a service. [42 CFR 438.10(g)(1)] C.2.20 [Applies to MCO, PIHP] If the state delegates this function, the contract requires the MCE to provide additional information that is available upon request, including information on the structure and operation of the MCE and the MCE's use of physician incentive plans. [42 CFR 438.10(g)(3)] C.2.21 [Applies to PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on the right to a state fair hearing, the method for obtaining a hearing, and rules governing representation at the hearing. [42 CFR 438.10(h)(1)] C.2.22 [Applies to PAHP] If the state delegates this function, the contract requires the MCE to provide information, upon request, to enrollees on the MCE's use of physician incentive plans. [42 CFR 438.10(h)(3)] C.3 Disenrollment Information C.3.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to notify all enrollees of their disenrollment rights annually, at a minimum. [42 CFR 438.10(f)(1)] C.3.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to send notice no less than 60 days before the start of each enrollment period if the state restricts disenrollment during periods lasting 90 days or longer. [42 CFR 438.10(f)(1)] C.5 Provider Terminations C.5.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to make a good faith effort to give written notice within 15 days when an enrollee's primary care provider (or a provider they saw on a regular basis) is terminated. [42 CFR 438.10(f)(5)] C.7 Timing for the Provision of Potential Enrollee Information C.7.01 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide the information described in the "Potential Enrollee Information" section of this review tool to potential enrollees at the time they first become eligible in a voluntary program or are first required to enroll in a mandatory program and within a timeframe that enables the potential enrollee to use the information in choosing among available plans. [42 CFR 438.10(e)(1)] C.8 Potential Enrollee Information C.8.1 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide general information to potential enrollees about: (1) Basic features of managed care, (2) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. (3) The MCE's responsibilities for coordination of enrollee care. [42 CFR 438.10(e)(2)(i)] C.8.2 [Applies to MCO, PIHP, PAHP, PCCM] If the State delegates this function, the contract requires the MCE to provide specific information to potential enrollees regarding each MCE program operating in the potential enrollee's service area, including: (1) Benefits covered, (2) Cost sharing, if any, (3) Service area, (4) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes at a minimum information on primary care physicians, specialists and hospitals, and (5) Benefits that are available under the state plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided (6) Counseling and referral services that are not covered under the contract because of moral or religious objections. [42 CFR 438.10(e)(2)(ii); 42 CFR 438.102(b)(1)(ii)(A); 1932(b)(3)(B)

(ii)] C.10 Easily Understood C.10.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to provide all enrollment notices, informational materials, and instructional materials in an easily understood format and manner. [42 CFR 438.10(b)(1)] C.10.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's written materials to use easily understandable language and format. [42 CFR 438.10(d)(1)(i)] C.10.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE's written materials to be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. [42 CFR 438.10(d)(1)(ii)] C.10.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to inform all enrollees and potential enrollees about information available in alternative formats and how to access those formats. [42 CFR 438.10(d)(1)(ii)] C.11 Mechanism C.11.01 [Applies to MCO, PIHP] The contract requires the MCE to have a mechanism in place to help enrollees and potential enrollees understand the requirements and benefits of the plan. [42 CFR 438.10(b)(2); 42 CFR 438.10(b)(3)] C.12 Language C.12.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to make its written information available in the prevalent non-English languages identified by the state in its particular service area. [42 CFR 438.10(c)(3)] C.13 Interpretation C.13.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires each MCE to make oral interpretation services available free of charge to each enrollee and potential enrollee. [42 CFR 438.10(c)(4)] C.13.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that oral interpretation is available for any language and how to access those services. [42 CFR 438.10(c)(5)] C.13.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that written information is available in prevalent languages and how to access those services. [42 CFR 438.10(c)(5)]

[vi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.1 Advance Directives D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100]

[vii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)]

[viii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.6 Provider Section D.6.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures include a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the MCE. [42 CFR 438.114(b)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(a)] F.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines emergency service as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished by a provider that is qualified to furnish such services under Medicaid. [1932(b)(2); 42 CFR 438.114(a)] F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d)(2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c)(1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d)(2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. [1932(b)(2); 42 CFR 438.114(c)(1)(i)] F.1.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(c)(1)(ii)(A)] F.1.8 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when a representative of the MCE instructs the enrollee to seek emergency services. [42 CFR 438.114(c)(1)(ii)(B)] F.1.9 [Applies to PCCM] The contract requires the PCCM to allow enrollees to obtain emergency services outside the primary

care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR 438.114(c)(2)(i)] F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)] F.1.11 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030] F.1.12 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 438.114(d)(2)] F.1.13 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge. [42 CFR 438.114(d)(3)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[ix] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d)(2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c)(1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d)(2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preautho45 CFR 164.308rization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if

he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[x] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicare & Medicaid Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.1 Advance Directives D.1.1 [Applies to MCO, PIHP] The contract requires that each MCE maintain written policies and procedures on advance directives for all adults receiving medical care by or through the MCE. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)] D.1.2 [Applies to MCO, PIHP] The contract prohibits the MCE from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(3)] D.1.3 [Applies to MCO, PIHP] The contract requires that each MCE educate staff concerning their policies and procedures on advance directives. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.102(a)(5)] D.1.4 [Applies to MCO, PIHP] The contract defines advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. [42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100]

[xi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. C. Beneficiary Notification C.2 Enrollee Information C.2.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be treated with respect and with due consideration for their dignity and privacy. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(ii)] C.2.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iii)] C.2.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to participate in decisions regarding their health care, including the right to refuse treatment. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(iv)] C.2.6 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to be free from any form of restraint or seclusion. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(v)] C.2.7 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to request and receive a copy of their medical records and request that they be amended or corrected. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(2)(vi)] C.2.8 [Applies to MCO, PIHP, PAHP] If the state delegates this function, the contract requires the MCE to provide information to enrollees on their right to obtain available and accessible health care services covered under the MCE contract. [42 CFR 438.10(f)(6)(iii); 42 CFR 438.100(b)(3)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.15 Enrollee Rights D.15.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(ii)] D.15.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iii)] D.15.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment. [42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iv)] D.15.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. [42 CFR 438.100(b)(2)(vi); 42 CFR 438.100(a)(1)] D.15.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to have written policies guaranteeing enrollees' right to request and receive a copy of his or her medical records, and to request that they be amended or corrected. [42 CFR 438.100(b)(2)(v); 42 CFR 438.100(a)(1)] D.15.6 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that each enrollee is free to exercise his or her rights without the MCE or its providers treating the enrollee adversely. [42 CFR 438.100(c)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.2 Compliance with State and Federal Laws J.2.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with all applicable Federal and State laws and regulations including: (1) Title VI of the Civil Rights Act of 1964 (2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities) (3) The Age Discrimination Act of 1975 (4) The Rehabilitation Act of 1973 - The Americans with Disabilities Act. [42 CFR 438.6(f)(1); 42 CFR 438.100(d)] J.2.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with applicable Federal and State laws regarding privacy and confidentiality. [42 CFR 438.6(f)(1); 42 CFR 438.100(d); 42 CFR 438.100(d)] J.2.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees. [42 CFR 438.100(a)(2)]

[xii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. C. Beneficiary Notification C.2 Enrollee Information C.2.19 [Applies to MCO, PIHP] If the state delegates this function, the contract requires the MCE to provide state-developed or state- approved information to enrollees on grievance, appeal and state fair hearing procedures and timeframes. This description must include at least the following: (1) Enrollees' right to a state fair hearing, (2) The method for obtaining a hearing, (3) The rules that govern representation at the hearing, (4) Enrollees' right to file grievances and appeals, (5) The requirements and timeframes for filing a grievance or appeal, (6) The availability of assistance for filing a grievance, appeal, or state fair hearing, (7) The toll free number the enrollee can use to file a grievance or appeal by phone, (8) The fact that benefits will continue, when requested by the enrollee, if the enrollee files a timely appeal or state fair hearing request, (9) The fact that the enrollee may be required to pay the cost of the continued services furnished while the appeal is pending if the final decision is adverse to the enrollee, (10) Any appeal rights the state makes available to providers to challenge the failure of the organization to cover a service. [42 CFR 438.10(g)(1)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.6 Grievance E.6.1 [Applies to MCO, PIHP] The contract requires the MCE to inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to a state fair hearing, how to obtain a hearing, and the representation rules at a hearing. [42 CFR 438.414; 42 CFR 438.10(g)(1)(i)] E.6.2 [Applies to MCO, PIHP] The contract requires the MCE to inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to file grievances and appeals and the requirements and timeframes for filing. [42 CFR 438.414; 42 CFR 438.10(g)(1)(ii)(iii)] E.6.3 [Applies to MCO, PIHP] The contract requires the MCE to inform providers and subcontractors, at the time they enter into a contract, about the availability of assistance with filing grievances and appeals. [42 CFR 438.414; 42 CFR 438.10(g)(1)(iv)] E.6.4 [Applies to MCO, PIHP] The contract requires the MCE to inform providers and subcontractors, at the time they enter into a contract, about the toll-free number to file oral grievances and appeals. [42 CFR 438.414; 42 CFR 438.10(g)(1)(v)] E.6.5 [Applies to MCO, PIHP] The contract requires that the MCE must inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing, although the enrollee may be liable for the cost of any continued benefits if the action is upheld. [42 CFR 438.414; 42 CFR 438.10(g)(1)(vi)] E.6.6 [Applies to MCO, PIHP] The contract requires the MCE to inform providers and subcontractors, at the time they enter into a contract, of any State-determined provider's appeal rights to challenge the failure of the organization to cover a service. [42 CFR 438.414; 42 CFR 438.10(g)(1)(vii)]

[xiii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. H. Grievance and Appeals H.2 -10 Appeals Process H.2 Actions That May Be Appealed H.2.1 [Applies to MCO, PIHP] The MCE contract must define "appeal" as the request for review of an action. [42 CFR 431.201; 42 CFR 438.400(b); 42 CFR 438.52(b)(2)(ii); 42 CFR 438.56(c); (added in this citation as it is referenced in B.2.01 of State Guide to CMS) 42 CFR 438.56(f)(2)] H.2.2 [Applies to MCO, PIHP] The MCE contract must define "action." The definition must include all of the elements described below. [42 CFR 431.201; 42 CFR 438.400(b); 42 CFR 438.52(b)(2)(ii); 42 CFR 438.56(f)(2)] Definition of Action: • Denial or limited authorization of a requested service, including the type or level of service. • Reduction, suspension, or termination of a previously authorized service. • Denial, in whole or in part, of payment for a service. • Failure to provide services in a timely manner, as defined by the State. • Failure of the MCE to process grievances, appeals or expedited appeals within required timeframes, or • For a rural area resident with only one MCO, the denial of a Medicaid enrollee's request to obtain services outside the network: 1. From any other provider (in terms of training, experience, and specialization) not available within the network. 2. From a non-network provider who is the main source of a service to the recipient, as long as that provider is given the same opportunity to become a participating provider, as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days. 3. Because the only plan or provider available does not provide the service due to moral or religious objections. 4. Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network. 5. The State determines that other circumstances warrant out-of-network treatment. H.11 Grievances H.11.1 [Applies to MCO, PIHP] The MCE contract defines a grievance as an expression of dissatisfaction about any matter other than an "action". [42 CFR 438.400(b)]

[xiv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. H. Grievance and Appeals H.10 Continuation of Benefits H.10.4 [Applies to MCO, PIHP] The contract requires the MCE to authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal was pending and if the MCE or State Fair Hearing Officer reverses a decision to deny, limit, or delay services. [42 CFR 438.424(a)] H.10.5 [Applies to MCO, PIHP] The contract requires the MCE to pay for disputed services received by the enrollee while the appeal was pending, unless State policy and regulations provide for the State to cover the cost of such services, when the MCE or State Fair Hearing Officer reverses a decision to deny authorization of the services. [42 CFR 438.424(b)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. K. State Obligations K.2 State Fair Hearing Process K.2.5 [Applies to MCO, PIHP] The contract requires the MCE to pay for disputed services received by the enrollee while the appeal was pending (unless State policy and regulations provide for the State to cover the cost of such services) when the MCE or State Fair Hearing Officer reverses a decision to deny authorization of the services. [42 CFR 438.424(b)]

[xv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. H. Grievance and Appeals H.10 Continuation of Benefits H.10.1

[Applies to MCO, PIHP] The contract requires that the MCE continue the enrollee's benefits while an appeal is in process if all of the following conditions are met: (1) The appeal is filed on or before the later of the following: (a) Within 10 days of the MCE mailing the notice of action, or (b) The intended effective date of the MCE's proposed action. (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) The services were ordered by an authorized provider. (4) The authorization period has not expired. (4) The enrollee requests extension of benefits. [42 CFR 438.420(a); 42 CFR 438.420(b)] H.10.2 [Applies to MCO, PIHP] The contract requires that if the MCE continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: (1) The enrollee withdraws the appeal, (2) The enrollee does not request a State Fair Hearing with continuation of benefits within 10 days from the date the MCE mails an adverse appeal decision, (3) A State Fair Hearing decision adverse to the enrollee is made, or (4) The service authorization expires or authorization limits are met. [42 CFR 438.420(c)] H.10.3 [Applies to MCO, PIHP] The contract provides that the MCE may recover the cost of the continued services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the MCE's action. [42 CFR 438.420(d); 42 CFR 431.230(b)]

[xvi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b) (4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]

[xvii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. B. Enrollment and Disenrollment B.4 Reenrollment B.4.1. [Applies to MCO, PIHP, PAHP, PCCM] If specified by the federal authority (SPA or waiver) approved by CMS, the contract provides for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. [42 CFR 438.56(g)]

[xviii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. B. Enrollment and Disenrollment B.5 Disenrollment B.5.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of a change in the enrollee's health status. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's utilization of medical services. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.4. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's diminished mental capacity. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.5. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCEs ability to furnish services to the enrollee or other enrollees). [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)]

[xix] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.8 [Applies to MCO, PCCM] The contract provides that if the MCE violates any other applicable requirements in 1903(m), 1932 or 1905(t) of the Act, the state may impose only the following sanctions: (1) Grant enrollees the right to disenroll without cause (2) Suspend all new enrollments to the MCE (3) Suspend payments for all new enrollments to the MCE. [43 CFR 438.700(d); 42 CFR 438.702(a)(3),(4)&(5); 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E)]

[xx] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.1 Network Adequacy E.1.3 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE maintain a network of appropriate providers that is supported by written agreements. [42 CFR 438.206(b)(1)] E.1.4 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. [42 CFR 438.206(b)(1)] E.1.5 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider how many Medicaid beneficiaries may enroll. [42 CFR 438.206(b)(1)(i)] E.1.6 [Applies to MCO, PIHP, PAHP] The contract requires that, when establishing and maintaining its network, the MCE consider the expected utilization of services, given the characteristics and health care needs of the specific Medicaid populations enrolled in the MCE. [42 CFR 438.206(b)(1)(ii)] E.1.7 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider the numbers and types (their training, experience and specialization) of providers required to provide the necessary Medicaid services. [42 CFR 438.206(b)(1)(iii)] E.1.8 [Applies to MCO, PIHP, PAHP] The contract requires that when establishing and maintaining its network, the MCE consider the numbers of network providers who are not accepting new Medicaid patients. [42 CFR 438.206(b)(1)(iv)] E.1.9 [Applies to MCO, PIHP, PAHP] The contract requires that, when establishing and maintaining its network, the MCE consider the geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. [42 CFR 438.206(b)(1)(v)] E. Providers and Provider Network E.5 Access E.5.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE and its providers meet the State standards for timely access to care and services, taking into account the urgency of need for services. [42 CFR 438.206(c)(1)(i)] E.5.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's network providers offer hours of operation that are no less than the hours offered to commercial enrollees or

are comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. [42 CFR 438.206(c)(1)(ii)] E.5.3 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to make services available 24 hours a day, 7 days a week, when medically necessary. [42 CFR 438.206(c)(1)(iii)] E.5.4 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to establish mechanisms to ensure that the network providers comply with the timely access requirements. [42 CFR 438.206(c)(1)(iv)] E.5.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to monitor providers regularly to determine compliance with the timely access requirements. [42 CFR 438.206(c)(1)(v)] E.5.6 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to take corrective action if it, or its providers, fail to comply with the timely access requirements. [42 CFR 438.206(c)(1)(vi)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.5 Women's Health Specialist F.5.01 [Applies to MCO, PIHP, PAHP] If a female enrollee's designated primary care physician is not a women's health specialist, the contract requires the MCE to provide the enrollee with direct access to a women's health specialist within the network for covered routine and preventive women's health care services. [42 CFR 438.206(b)(2)] F.6 Second Opinions F.6.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion outside the network, at no cost to the enrollee. [42 CFR 438.206(b)(3)] F.7 Out-of-Network Care F.7.1 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCE must adequately and timely cover the services out of network, for as long as the MCE is unable to provide them. [42 CFR 438.206(b)(4)] F.7.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to coordinate payment with out of network providers and ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network. [42 CFR 438.206(b)(5)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. G. Quality and Utilization Management G.7 Cultural Competence G.7.01 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. [42 CFR 438.206(c)(2)]

[xxi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.6 Provider Section D.6.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. [42 CFR 438.214(c)] I. Program Integrity I.1 Exclusions I.1.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE not employ or contract with providers excluded from participation in Federal health care programs. [42 CFR 438.214(d)] K. State Obligations K.8 Credentialing and Re-credentialing Policy K.8.01 [Applies to MCO, PIHP, PAHP] The contract specifies that the state-established uniform provider credentialing and re credentialing policy must be followed by the MCE. [42 CFR 438.214(b)(1)]

[xxii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.11 Timely Payment D.11.1 [Applies to MCO] The contract requires that the MCE will meet the requirements of FFS timely payment, including the paying of 90% of all clean claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99 percent of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt. [42 CFR 447.45 (d)(3)] D.11.2 [Applies to MCO] The contract requires that the MCE ensure that the date of receipt is the date the MCE receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment. [42 CFR 447.45 (d)(3)]

[xxiii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. D. MCE Policies, Procedures, and Systems D.6 Provider Section D.6.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures include a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the MCE. [42 CFR 438.114(b)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b) (2); 42 CFR 438.114(a)] F.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines emergency service as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished by a provider that is qualified to furnish such services under Medicaid. [1932(b) (2); 42 CFR 438.114(a)] F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the

stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d) (2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c) (1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d) (2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. [1932(b) (2); 42 CFR 438.114(c) (1) (i)] F.1.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(c)(1)(ii)(A)] F.1.8 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when a representative of the MCE instructs the enrollee to seek emergency services. [42 CFR 438.114(c)(1)(ii)(B)] F.1.9 [Applies to PCCM] The contract requires the PCCM to allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR 438.114(c)(2)(i)] F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)] F.1.11 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030] F.1.12 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 438.114(d)(2)] F.1.13 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge. [42 CFR 438.114(d)(3)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[xxiv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)]

[xxv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. D. MCE Policies, Procedures, and Systems D.6 Provider Section D.6.2 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE's provider selection policies and procedures include a uniform documented process for credentialing and re-credentialing providers who have signed contracts with the MCE. [42 CFR 438.114(b)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines an emergency medical condition as a medical condition manifesting itself by acute

symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b) (2); 42 CFR 438.114(a)] F.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines emergency service as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished by a provider that is qualified to furnish such services under Medicaid. [1932(b) (2); 42 CFR 438.114(a)] F.1.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract defines post stabilization services as covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the enrollee's condition when the MCE does not respond to a request for pre-approval within 1 hour, the MCE cannot be contacted, or the MCE's representative and the treating physician cannot reach an agreement concerning the enrollee's care and an MCE physician is not available for consultation. [1852(d) (2); 42 CFR 438.114(a); 42 CFR 438.114(e); 42 CFR 422.113(c) (1)] F.1.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services and post stabilization care services. [1852(d) (2); 42 CFR 438.114(b); 42 CFR 422.113(c)] F.1.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. [1932(b) (2); 42 CFR 438.114(c) (1) (i)] F.1.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [1932(b)(2); 42 CFR 438.114(c)(1)(ii)(A)] F.1.8 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from denying payment for treatment obtained when a representative of the MCE instructs the enrollee to seek emergency services. [42 CFR 438.114(c)(1)(ii)(B)] F.1.9 [Applies to PCCM] The contract requires the PCCM to allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnished the services. [42 CFR 438.114(c)(2)(i)] F.1.10 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from limiting what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. [42 CFR 438.114(d)(1)(i)] F.1.11 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030] F.1.12 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. [42 CFR 438.114(d)(2)] F.1.13 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the enrollee, determines that the enrollee is sufficiently stabilized for transfer or discharge. [42 CFR 438.114(d)(3)] F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[xxvi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to allow the emergency services provider a minimum of ten calendar days to notify the primary care provider, MCE or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify. [42 CFR 438.114(d)(1)(ii); 6/14/2002 final rule, Preamble comments on page 41030]

[xxvii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. G. Quality and Utilization Management G.8 Special Health Care Needs G.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. [42 CFR 438.208(c)(2)]

[xxviii] UNITED STATES. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

[xxix] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)]

[xxx] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicare & Medicaid Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.2 Family Planning F.2.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from restricting the enrollee's free choice of family planning services and supplies providers. [1902(a)(23); 42 CFR 431.51(b)(2)]

[xxxi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. B. Enrollment and Disenrollment B.5 Disenrollment B.5.2. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of a change in the enrollee's health status. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.3. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's utilization of medical services. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.4. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's diminished mental capacity. [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)] B.5.5. [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE may not request disenrollment because of the enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCEs ability to furnish services to the enrollee or other enrollees). [1903(m)(2)(A)(v); 42 CFR 438.56(b)(2)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. C. Beneficiary Notification C.6 Sales and Transactions C.6.01 [Applies to MCO] The contract requires the MCE to make any reports of transactions between the MCE and parties in interest that are provided to the State, or other agencies available to MCE enrollees upon reasonable request. [1903(m)(4)(B)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.12 Encounter Data D.12.01 [Applies to MCO] The contract requires the MCE to maintain sufficient patient encounter data to identify the physician who delivers services to patients. [1903(m)(2)(A)(xi)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.13 Nonpayment F.13.1 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for organ transplants unless the State Plan provides, and the MCE follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility

of high quality care to enrollees. [1903(i) final sentence; 1903(i)(1)] F.13.2 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2),[203]. [1903(i) final sentence; 1903(i)(2)(A)] F.13.3 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person). [1903(i) final sentence; 1903(i)(2)(B)] F.13.4 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. [1903(i) final sentence; 1903(i)(2)(C)] F.13.5 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. [1903(i) final sentence; 1903(i)(16)] F.13.6 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. [1903(i) final sentence; 1903(i)(17)] F.13.7 [Applies to MCO, PCCM] The contract prohibits the MCE from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act. [1903(i) final sentence; 1903(i)(18)] F.15 FQHC Wrap Payments F.15.01 [Applies to MCO] The contract provides that if a MCE enters into a contract for the provision of services with a Federally--qualified health center (FQHC) or a rural health clinic (RHC), the MCE shall provide payment that is not less than the level and amount of payment which the MCE would make for the services if the services were furnished by a provider which is not a FQHC or RHC. [1903(m)(2)(A)(ix)] F.16 Drug Rebates F.16.1 [Applies to MCO] The contract provides that covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the MCE shall be subject to the same rebate requirements as the State is subject under section 1927 and that the State shall collect such rebates from manufacturers. [1903(m)(2)(A)(xiii); SMDL#10-006] F.16.2 [Applies to MCO] The contract requires the MCE to report to the State, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to enrollees for which the entity is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary. [1903(m)(2)(A)(xiii); SMDL#10-006] F.17 EHR Incentive Payments F.17.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse electronic health records (EHR) incentive payments to eligible professionals, the contract establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate , in accordance with 42 CFR 438.6 c)(5)(iii). [1903(t); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.304; 42 CFR 495.310(c); 42 CFR 447.253(e); 42 CFR 495.370(a); SMD# 09-006, Attachment A] F.17.2 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse EHR incentive payments to eligible professionals, the contract includes a description of the process and methodology for ensuring and verifying that incentive payments are paid directly to the eligible professional (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate. [1903(t)(6)(A)(ii); 42 CFR 495.310(k); 42 CFR 495.332(c)(9)] F.17.3 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse EHR incentive payments to eligible professionals, the contract includes a description of the process and methodology for verifying that all incentive payment reassignments to an entity promoting the adoption of certified EHR technology, as designated by the State, are voluntary for the Medicaid eligible professional involved. [1903(t)(6)(A)(ii); 42 CFR 495.310(k); 42 CFR 495.332(c)(9)] F.17.4 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse EHR incentive payments to eligible professionals, the contract includes a description of the process and methodology for verifying that entities promoting the adoption of certified EHR technology do not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology. [1903(t)(6)(A)(ii); 42 CFR 495.310(k); 42 CFR 495.332(c)(9)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. I. Program Integrity I.1 Exclusions I.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract establishes that FFP is not available for any amounts paid to an MCE that could be excluded from participation in Medicare or Medicaid for any of the following reasons: (1) The MCE is controlled by a sanctioned individual (2) The MCE has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act (3) The MCE employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (a) Any individual or entity excluded from participation in Federal health care programs. (b) Any entity that would provide those services through an excluded individual or entity. [1903(i)(2); 42 CFR 431.55(h); 42 CFR 438.808; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMD letter 6/12/08; SMD letter 1/16/09] I.3 Disclosure I.3.1 [Applies to MCO, HIO, PIHP, PAHP, PCCM] The contract requires the MCE to disclose to the state any persons or corporations with an ownership or control interest in the MCE that: (1) has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the MCE's equity, (2) owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the MCE if that interest equals at least 5% of the value of the MCE's assets, (3) is an officer or director of an MCE organized as a corporation, or (4) Is a partner in an MCE organized as a partnership. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100-104] I.3.2 [Applies to MCO, HIO, PIHP, PAHP, PCCM] The contract requires the MCE to

disclose the following information to the state for any person or corporation with ownership or control interest in the MCE: (1) Name and address (The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.) (2) Date of birth and Social Security Number (in the case of an individual). (3) Other tax identification number (in the case of a corporation) (4) Whether the person (individual or corporation) with an ownership or control interest in the MCE or an MCE subcontractor is related to another person with ownership or control interest in the MCE as a spouse, parent, child, or sibling. (5) The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest. (6) The name, address, date of birth, and Social Security Number of any managing employee of the MCE. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100-103; 42 CFR 455.104(b)] I.3.3 [Applies to MCO, HIO, PIHP, PAHP] The contract requires the MCE to disclose information on individuals or corporations with an ownership or control interest in the MCE to the State at the following times: (i) When the MCE submits a proposal in accordance with the state's procurement process (ii) When the MCE executes a contract with the state, (iii) When the state renews or extends the MCE contract (iv) Within 35 days after any change in ownership of the MCE. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100- 103; 42 CFR 455.104(c)(3)] I.3.4 [Applies to PCCM] The contract requires the MCE to disclose information on individuals or corporations with an ownership or control interest in the MCE to the state at the following times: (i) When the provider submits a provider application (ii) When the provider executes a provider agreement with the state (iii) Upon request of the state during the revalidation of the provider enrollment (iv) Within 35 days after any change in ownership of the provider. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100-103; 42 CFR 455.104(c)(1) and (4)] I.4 Reporting Transactions I.4.01 [Applies to MCO] The contract requires the MCE to report to the State and, upon request, to the Secretary of DHHS, the Inspector General of the DHHS, and the Comptroller General a description of transactions between the MCE and a party in interest (as defined in section 1318(b) of such Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the MCE and such a party (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the MCE and such a party, but not including salaries paid to employees for services provided in the normal course of their employment. (iii) Any lending of money or other extension of credit between the MCE and such a party. [1903(m)(4)(A)] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.1 Inspection J.1.2 [Applies to MCO, PIHP, PAHP] The risk contract requires that the Secretary, DHHS and the State (or any person or organization designated by either) have the right to audit and inspect any books or records of the MCE or its subcontractors pertaining to: 1. The ability of the MCE to bear the risk of financial losses 2. Services performed or payable amounts under the contract. [1903(m)(2)(A)(iv)] J.6 Sanctions J.6.1 [Applies to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.8 [Applies to MCO, PCCM] The contract provides that if the MCE violates any other applicable requirements in 1903(m), 1932 or 1905(t) of the Act, the state may impose only the following sanctions: (1) Grant enrollees the right to disenroll without cause (2) Suspend all new enrollments to the MCE (3) Suspend payments for all new enrollments to the MCE. [43 CFR 438.700(d); 42 CFR 438.702(a)(3),(4)&(5); 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E)] J.6.12 [Applies to MCO] The MCE contract specifies that the state must impose mandatory temporary management and grant enrollees the right to terminate MCE enrollment without cause when an MCE repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438. The state may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the MCE can ensure the sanctioned behavior will not reoccur. [42 CFR 438.706(b); 1932(e)(2)(B)(ii)]

J.7 Termination J.7.01 [Applies to MCO, PCCM] The contract specifies that the state may terminate an MCE contract, and place enrollees into a different MCE or provide Medicaid benefits through other State Plan authority, if the State determines that the MCE has failed to carry out the substantive terms of its contracts or meet the applicable requirements of 1932, 1903(m) or 1905(t) of the Act. [42 CFR 438.708(a); 42 CFR 438.708(b); 1903(m); 1905(t); 1932] J.9 Insolvency J.9.5 [Applies to MCO, PIHP] The contract requires the MCE to meet states solvency standards for private health maintenance organizations, or be licensed or certified by the state as a risk-bearing entity. [1903(m)(1); 42 CFR 438.116(b)(2)(i); 42 CFR 438.116(b)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. K. State Obligations K.4 Contract Sanctions and Terminations K.4.2 [Applies to MCO] The contract specifies that if the state imposes temporary management because an MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438 , the state must notify affected enrollees of their right to terminate enrollment without cause. [42 CFR 438.706(b)]

[xxxii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. C. Beneficiary Notification C.12 Language C.12.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to make its written information available in the prevalent non-English languages identified by the state in its particular service area. [42 CFR 438.10(c)(3)] C.13 Interpretation C.13.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires each MCE to make oral interpretation services available free of charge to each enrollee and potential enrollee. [42 CFR 438.10(c)(4)] C.13.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that oral interpretation is available for any language and how to access those services. [42 CFR 438.10(c)(5)] C.13.3 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to notify its enrollees that written information is available in prevalent languages and how to access those services. [42 CFR 438.10(c)(5)] H. Grievance and Appeals H.3 Notice of Adverse Action Requirements H.3.2 [Applies to MCO, PIHP] The contract requires the MCE to provide the notice of adverse action in writing. The notice must meet all of the following requirements: (1) Be available in the state-established prevalent non- English languages in its service area. (2) Be available in alternative formats for persons with special needs. (3) Use easily understood language and format. [42 CFR 438.404(a); 42 CFR 438.10(c) and (d)] K. State Obligations K.1 Enrollee Information K.1.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract specifies that the state identifies the prevalent non-English languages spoken by enrollees and potential enrollees and provides that information to the MCE. [42 CFR 438.10(c)(1)]

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

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

[xxxiv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. I. Program Integrity I.3 Disclosure I.3.2 [Applies to MCO, HIO, PIHP, PAHP, PCCM] The contract requires the MCE to disclose the following information to the state for any person or corporation with ownership or control interest in the MCE: (1) Name and address (The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.) (2) Date of birth and Social Security Number (in the case of an individual). (3) Other tax identification number (in the case of a corporation) (4) Whether the person (individual or corporation) with an ownership or control interest in the MCE or an MCE subcontractor is related to another person with ownership or control interest in the MCE as a spouse, parent, child, or sibling. (5) The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest. (6) The name, address, date of birth, and Social Security Number of any managing employee of the MCE. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100-103; 42 CFR 455.104(b)] I.3.3 [Applies to MCO, HIO, PIHP, PAHP] The contract requires the MCE to disclose information on individuals or corporations with an ownership or control interest in the MCE to the State at the following times: (i) When the MCE submits a proposal in accordance with the state's procurement process (ii) When the MCE executes a contract with the state, (iii) When the state renews or extends the MCE contract (iv) Within 35 days after any change in ownership of the MCE. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100- 103; 42 CFR 455.104(c)(3)] I.3.4 [Applies to PCCM] The contract requires the MCE to disclose information on individuals or corporations with an ownership or control interest in the MCE to the state at the following times: (i) When the provider submits a provider application (ii) When the provider executes a provider agreement with the state (iii) Upon request of the state during the revalidation of the provider enrollment (iv) Within 35 days after any change in ownership of the provider. [1124(a)(2)(A); 1903(m)(2)(A)(viii); 42 CFR 455.100-103; 42 CFR 455.104(c)(1) and (4)]

[xxxv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. G. Quality and Utilization Management Medical Record Content G.6.01 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires that medical record content must include at a minimum for hospitals and mental hospitals: (1) Identification of the beneficiary. (2) Physician name. (3) Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 456.172 (mental hospitals) or 456.70 (hospitals). (4) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals). (5) Reasons and plan for continued stay if applicable. (6) Other supporting material the committee believes appropriate to include. For non-mental hospitals only: (7) Date of operating room reservation. (8) Justification of emergency admission if applicable. [42 CFR 456.111; 42 CFR 456.211]

[xxxvi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)]

[xxxvii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. BALTIMORE, MD: Center for Medicaid & Chip Services, 2015. Print. F. Coverage F.1 Emergency and Post-Stabilization Services F.1.14 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization services obtained within or outside the MCE network that are pre-approved by a MCE provider or representative. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(i)] F.1.15 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post-stabilization care services obtained within or outside the MCE network that are not pre-approved by a MCE provider or representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCE for pre-approval of further post-stabilization care services. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(ii) and (iii)] F.1.16 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE did not respond to a request for pre-approval within 1 hour. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.17 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE could not be contacted for pre-approval. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.18 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to cover post stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the MCE network, when the MCE representative and the treating physician could not reach agreement concerning the enrollee's care and a MCE physician was not available for consultation. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iii)] F.1.19 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to limit charges to enrollees for post-stabilization care services to an amount no greater than what the MCE would charge the enrollee if he or she obtained the services through the MCE. [42 CFR 438.114(e); 42 CFR 422.113(c)(2)(iv)] F.1.20 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician with privileges at the treating hospital assumes responsibility for the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(i)] F.1.21 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE physician assumes responsibility for the enrollee's care through transfer. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(ii)] F.1.22 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when a MCE representative and the treating physician reach an agreement concerning the enrollee's care. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iii)] F.1.23 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that the MCE's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. [42 CFR 438.114(e); 42 CFR 422.113(c)(3)(iv)]

[xxxviii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. K. State Obligations K.5 No Supplemental Payments K.5.01 [Applies to MCO, PIHP, PAHP] The contract provides that the State agency must ensure that no payment is made to a provider other than the MCE for services available under the contract between the State and the MCE, except when these payments are specifically provided for in title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract, for graduate medical education. [42 CFR 438.60]

[xxxix] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.1 Network Adequacy E.8 Physician Incentive Plan E.8.1 [Applies to MCO, PIHP, PAHP] The contract requires that the MCE may only operate a PIP if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(1); 42 CFR 438.6(h)] E.8.2 [Applies to MCO, PIHP, PAHP] The contract requires that if the MCE puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the MCE must ensure

that the physician/physician group has adequate stop-loss protection. [1903(m)(2)(A)(x); 42 CFR 422.208(c)(2); 42 CFR 438.6(h)]

[xl] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.11 Provider Preventable Conditions F.11.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) is identified in the State plan; (ii) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the beneficiary; (iv) is auditable; (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. [42 CFR 438.6(f)(2)(i); 42 CFR 434.6(a)(12)(i); 42 CFR 447.26(b)]

[xli] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. J. General Terms and Conditions A.1.1. [Applies to all entity types.] The contract submission is signed and dated by all parties. A.1.2. [Applies to all entity types.] The contract submission is complete. That is: 1) All pages, appendices, attachments, etc. were submitted to CMS. 2) Any documents incorporated by reference (including, but not limited to, state statute, state regulation, or other binding document, such as a member handbook) to comply with federal regulations and the requirements of this review tool were submitted to CMS. A.1.3. [Applies to all entity types.] If the contract submission is an amendment, CMS has received and approved all previous amendments to the base contract. A.1.4. [Applies to all entity types.] If the contract submission includes capitation rates, CMS has completed the CMS rate-setting review tool and determined the rates to be compliant with federal requirements. A.1.5. [Applies to all entity types.] The contract submission complies with the federal authority(ies) approved by CMS. For example, if the contractor delivers services for a program authorized under 1915(b)/1915(c) concurrent authority, the contract is in compliance with the approved 1915(b)/1915(c) waivers.

[xlii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.12 Cost Sharing F.12.1 [Applies to MCO, PIHP, PAHP] The contract requires that any cost sharing imposed on Medicaid enrollees is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.60. [1916(a)(2)(D); 1916(b)(2)(D); 42 CFR 438.108; 42 CFR 447.50-60; SMD letter 6/16/06]

[xliii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval.* Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. F. Coverage F.12 Cost Sharing F.12.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract requires the MCE to exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services. The contract requires the MCE to exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services. [42 CFR 447.52(h); 42 CFR 42 CFR 447.56 (a)(1)(x); ARRA 5006(a); SMD 10-001]

[xliv] United States. Department of Health and Human Services. Centers for Medicare & Medicaid Services. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Centers for Medicare & Medicaid Services, 2015. Print. J. General Terms and Conditions J.9 Insolvency J.9.1 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for the MCE's debts, in the event the MCE becomes insolvent. [42 CFR 438.106(a); 1932(b)(6)] J.9.2 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state does not pay the MCE. [42 CFR 438.106(b)(1); 1932(b)(6)] J.9.3 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state or MCE does not pay the provider that furnishes the service under a contractual, referral, or other arrangement. [42 CFR 438.106(b)(2); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)] J.9.4 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCE provided the services directly. [42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)]

[xlv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. D. MCE Policies, Procedures, and Systems D.5 Program Integrity D.5.1 [Applies to MCO, PIHP] The contract requires that the MCE have administrative and management arrangements or procedures (including a mandatory compliance plan) that are designed to guard against fraud and abuse. [42 CFR 438.608(a)] D.5.2 [Applies to MCO, PIHP] The contract requires that the MCE have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State program integrity standards. [42 CFR 438.608(b)(1)] D.5.3 [Applies to MCO, PIHP] The contract requires that the MCE designate a compliance officer and a compliance committee that are accountable to senior management. [42 CFR 438.608(b)(2)] D.5.4 [Applies to MCO, PIHP] The contract requires that the MCE have arrangements or procedures that include effective training and education for the compliance officer and the organization's employees. [42 CFR 438.608(b)(3)] D.5.5 [Applies to MCO, PIHP] The contract requires that the MCE have effective lines of communication between the compliance officer and the organization's employees. [42 CFR 438.608(b)(4)] D.5.6 [Applies to MCO, PIHP] The contract requires that the MCE enforce program integrity standards through well-publicized disciplinary guidelines. [42 CFR 438.608(b)(5)] D.5.7 [Applies to MCO, PIHP] The contract requires that the MCE provide for internal program integrity monitoring and auditing. [42 CFR 438.608(b)(6)] D.5.8 [Applies to MCO, PIHP] The contract requires that the MCE provide for prompt response to detected program integrity offenses and develop corrective action initiatives. [42 CFR 438.608(b)(7)]

[xlvi] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. I. Program Integrity I.2 Requirements, procedures, and reporting I.2.4 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having a director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09] I.2.5 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having a person with ownership of more than 5% of the MCE's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09] I.2.6 [Applies to MCO, PIHP, PAHP, PCCM] The contract prohibits the MCE from knowingly having an employment, consulting, or other agreement with an individual or entity for the provision of MCE contract items or services who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs. [1932(d)(1); 42 CFR 438.610; SMD letter 6/12/08; SMD letter 1/16/09]
United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. K. State Obligations K.3 Program Integrity K.3.1 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the State learns that an MCE has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the State,: (1) Must notify the Secretary of the noncompliance. (2) May continue an existing agreement with the MCE unless the Secretary directs otherwise. (3) May not renew or extend the existing agreement with the MCE unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement. [42 CFR 438.610(c)]

[xlvii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. I. Program Integrity I.1 Exclusions I.1.2 [Applies to MCO, PIHP, PAHP, PCCM] The contract establishes that FFP is not available for any amounts paid to an MCE that could be excluded from participation in Medicare or Medicaid for any of the following reasons: (1) The MCE is controlled by a sanctioned individual (2) The MCE has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act (3) The MCE employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (a) Any individual or entity excluded from participation in Federal health care programs. (b) Any entity that would provide those services through an excluded individual or entity. [1903(i)(2); 42 CFR 431.55(h); 42 CFR 438.808; 42 CFR 1001.1901(c); 42 CFR 1002.3(b)(3); SMD letter 6/12/08; SMD letter 1/16/09]

[xlviii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. F. Coverage F.14 Enhanced Payments for Primary Care Services F.14.1 [Applies to MCO, PIHP, PAHP] For calendar years (CY) 2013 and 2014 the contract requires the MCE to make enhanced payments for primary care services delivered by, or under the supervision of, a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.400(a); Increased Payment to PCPs Q&A] F.14.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to base enhanced primary care payments on the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the CY 2009 Medicare physician fee schedule conversion factor. If no applicable rate is established by Medicare, the MCE uses the rate specified in a fee schedule established by CMS. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405; Increased Payment to PCPs Q&A] F.14.3 [Applies to MCO, PIHP, PAHP] The contract stipulates that the MCE make enhanced primary care payments for all Medicaid- covered Evaluation and Management (E&M) billing codes 99201 through 99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, or their successor codes. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(A); 42 CFR 447.405(c); Increased Payment to PCPs Q&A] F.14.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to provide documentation to the state, sufficient to enable the state and CMS to ensure that primary care enhanced payments were made to network providers. [11/06/2012 final rule; 42 CFR 438.6(c)(5)(vi)(B); Increased Payment to PCPs Q&A] F.17 EHR Incentive Payments F.17.1 [Applies to MCO, PIHP, PAHP, PCCM] If the state requires the MCE to disburse electronic health records (EHR) incentive payments to eligible professionals, the contract establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate , in accordance with 42 CFR 438.6 c)(5)(iii). [1903(t); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.332 (d)(2); 42 CFR 438.6(c)(5)(iii); 42 CFR 495.304; 42 CFR 495.310(c); 42 CFR 447.253(e); 42 CFR 495.370(a); SMD# 09-006, Attachment A] F.17.5 [Applies to MCO, PIHP, PAHP, PCCM] If the state delegates any of its responsibilities for administering EHR incentive payments to the MCE, the contract should describe the delegated activities. [42 CFR 438.6(c)(4)(ii)(A); Page 44514, Medicare and Medicaid Programs: Electronic Health Care Incentive Program: Final Rule, July 28, 2010]

[xlix] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. E. Providers and Provider Network E.7 Balance Billing E.7.1 [Applies to MCO, PIHP, PAHP] The contract obligates the MCE to require that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers). [1932(b)(6); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.230(c)] J. General Terms and Conditions J.4 Subcontracts J.4.1 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to oversee and be held accountable for any functions or responsibilities it delegates to a subcontractor. [42 CFR 438.230(a)(1)] J.4.2 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to evaluate a prospective subcontractor's ability to perform the activities prior to delegating the activities. [42 CFR 438.230(b)(1)] J.4.3 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to

execute a written agreement with any subcontractors that specifies the activities and report responsibilities delegated to the subcontractor. [42 CFR 438.230(b)(2)(i)] J.4.5 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to execute a written agreement with any subcontractors that specifies the MCE's right to revoke the subcontract or impose sanctions if the subcontractor's performance is inadequate. [42 CFR 438.230(b)(2)(ii)] J.4.6 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to monitor the subcontractor's performance on an ongoing basis. This includes conducting formal reviews according to a review schedule that is set by the State and consistent with industry standards and State MCO laws. [42 CFR 438.230(b)(3)] J.4.7 [Applies to MCO, PIHP, PAHP] The contract requires the MCE and subcontractor to take corrective action on any identified deficiencies or areas of improvement. [42 CFR 438.230(b)(4)] J.9 Insolvency J.9.3 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services provided to the enrollee, for which the state or MCE does not pay the provider that furnishes the service under a contractual, referral, or other arrangement. [42 CFR 438.106(b)(2); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)] J.9.4 [Applies to MCO, PIHP, PAHP] The MCE contract specifies that Medicaid enrollees are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCE provided the services directly. [42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230; 1932(b)(6)]

[i] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.11 [Applies to MCO] The MCE contract specifies the circumstances under which the state will impose optional temporary management. Temporary management may only be imposed when: There is continued egregious behavior by the MCE, there is substantial risk to enrollees' health, or the sanction is necessary to ensure the health of the MCE's enrollees. [42 CFR 438.706(a); 1932(e)(2)(B)(i)] J.6.12 [Applies to MCO] The MCE contract specifies that the state must impose mandatory temporary management and grant enrollees the right to terminate MCE enrollment without cause when an MCE repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438. The state may not delay the imposition of temporary management to provide a hearing and may not terminate temporary management until it determines that the MCE can ensure the sanctioned behavior will not reoccur. [42 CFR 438.706(b); 1932(e)(2)(B)(ii)] K. State Obligations K.4 Contract Sanctions and Terminations K.4.2 [Applies to MCO] The contract specifies that if the state imposes temporary management because an MCO has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 CFR 438 , the state must notify affected enrollees of their right to terminate enrollment without cause. [42 CFR 438.706(b)]

[ii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.1 [Applies to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the MCE distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the state may impose a civil monetary penalty of up to $25,000 for each distribution. [42 CFR 438.700(c); 42 CFR 438.704(b)(1)(iv); 1932(e)(1)(A); 1932(e)(2)(A)(i)]

United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. K. State Obligations K.4 Contract Sanctions and Terminations K.4.1 [Applies to MCO, PCCM] The contract specifies that if the state imposes a civil monetary penalty on the MCE for charging premiums or charges in excess of the amounts permitted under Medicaid, the state deducts the amount of the overcharge from the penalty and returns it to the affected enrollee. [42 CFR 438.704(c)]

[lii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. BALTIMORE, MD: Center for Medicaid & Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.1 [Applies to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.7 [Applies to MCO, PIHP, PAHP, PCCM] The contract provides that if the MCE distributes marketing materials that have not been approved by the State or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, the state may impose a civil monetary penalty of up to $25,000 for each distribution. [42 CFR 438.700(c); 42 CFR 438.704(b)(1)(iv); 1932(e)(1)(A); 1932(e)(2)(A)(i)]

[liii] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. BALTIMORE, MD: Center for Medicaid & Chip Services, 2015. Print. J. General Terms and Conditions J.6 Sanctions J.6.1 [Applies to MCO, PCCM] The contract provides that if the MCE fails to substantially provide medically necessary services to an enrollee that the MCE is required to provide under law or under its contract with the State, the state may impose a civil monetary penalty of up to $25,000 for each failure to provide services. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(1); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(i); 1903(m)(5)(A)(i); 1903(m)(5)(B); 1932(e)(1)(A)(i); 1932(e)(2)(A)(i)] J.6.2 [Applies to MCO, PCCM] The contract provides that If the MCE imposes premiums or charges on enrollees that are in excess of those permitted in the Medicaid program, the state may impose a civil monetary of up to $25,000 or double the amount of the excess charges (whichever is greater) The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(2); 42 CFR 438.702(a)(1); 42 CFR 438.704(c); 1903(m)(5)(A)(ii); 1903(m)(5)(B); 1932(e)(1)(A)(ii); 1932(e)(2)(A)(iii)] J.6.3 [Applies to MCO, PCCM] The contract provides that if the MCE discriminates among enrollees on the basis of their health status or need for health services, the state may impose a civil monetary penalty of up to $100,000 for each instance of discrimination. The state may impose a civil monetary penalty of up to $15,000 for each individual the MCE did not enroll because of a discriminatory practice, up to the $100,000 maximum. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(3); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2)&(3); 1903(m)(5)(A)(iii); 1903(m)(5)(B); 1932(e)(1)(A)(iii); 1932(e)(2)(A)(ii)& (iv)] J.6.4 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to CMS or to the State, the state may impose a civil monetary penalty of up to $100,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary

management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [1932(e)(1)(iv); 42 CFR 438.700(b)(4); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(2); 1903(m)(5)(A)(iv)(I); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(I); 1932(e)(2)(A)(ii)] J.6.5 [Applies to MCO, PCCM] The contract provides that if the MCE misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider, the state may impose a civil monetary penalty of up to $25,000 for each instance of misrepresentation. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.702(a)(1); 42 CFR 438.700(b)(5); 42 CFR 438.704(b)(1)(ii); 1903(m)(5)(A)(iv)(II); 1903(m)(5)(B); 1932(e)(1)(A)(iv)(II); 1932(e)(2)(A)(i)] J.6.6 [Applies to MCO, PCCM] The contract provides that if the MCE fails to comply with the Medicare physician incentive plan requirements, the state may impose a civil monetary penalty of up to $25,000 for each failure to comply. The state may also: (1) Appoint temporary management to the MCE (2) Grant enrollees the right to disenroll without cause (3) Suspend all new enrollments to the MCE (4) Suspend payments for new enrollments to the MCE. [42 CFR 438.700(b)(6); 42 CFR 438.702(a)(1); 42 CFR 438.704(b)(1)(iii); 1903(m)(5)(A)(v); 1903(m)(5)(B); 1932(e)(1)(A)(v); 1932(e)(2)(A)(i)] J.6.8 [Applies to MCO, PCCM] The contract provides that if the MCE violates any other applicable requirements in 1903(m), 1932 or 1905(t) of the Act, the state may impose only the following sanctions: (1) Grant enrollees the right to disenroll without cause (2) Suspend all new enrollments to the MCE (3) Suspend payments for all new enrollments to the MCE. [43 CFR 438.700(d); 42 CFR 438.702(a)(3),(4)&(5); 1932(e)(2)(C); 1932(e)(2)(D); 1932(e)(2)(E)] J.6.9 [Applies to MCO, PIHP, PAHP, PCCM] The MCE contract provides that the state may impose additional sanctions provided for under state statutes or regulations to address noncompliance. [42 CFR 438.702(b)]

[liv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. State Guide to CMS Criteria for Managed Care Contract Review and Approval. Baltimore, MD: CENTER FOR MEDICAID CHIP SERVICES, 2015. Print. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b) (4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]

[lv] United States. DEPARTMENT OF HEALTH AND HUMAN SERVICES. *State Guide to CMS Criteria for Managed Care Contract Review and Approval*. Baltimore, MD: Center for Medicaid and Chip Services, 2015. Print. J. General Terms and Conditions J.3 HIPPA J.3.01 [Applies to MCO, PIHP, PAHP] The contract requires the MCE to use and disclose individually identifiable health information, such as medical records and any other health or enrollment information that identifies a particular enrollee, in accordance with the confidentiality requirements in 45 CFR parts 160 and 164. [42 CFR 438.208(b)(4); 42 CFR 438.224; 45 CFR Part 160; 45 CFR Part 164]