TUFTS HEALTH PUBLIC PLANS

AMENDMENT NO. 4

The March 1, 2017 Agreement between the State of Rhode Island, (formerly known as State of Rhode Island and Providence Plantations) Executive Office of Health and Human Services ("EOHHS") and Tufts Health Public Plans (the "Contractor"), is hereby amended effective July 1, 2020.

WHEREAS, as of effective date of this Amendment No. 4, the Agreement is hereby amended as follows:

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1. **Section 2.07 COORDINATION WITH OUT-OF-PLAN SERVICES AND OTHER HEALTH/SOCIAL SERVICES AVAILABLE TO MEMBERS** is amended to be renumbered as follows:

2.07.01	**General**
2.07.02	**Non-Emergency Transportation**
2.07.03	**Special Education**
2.07.04	**Department of Behavioral Health, Developmental Disabilities and Hospitals**
2.07.05	**Rhode Island Department of Human Services**
2.07.06	**Rhode Island Department of Health**
2.07.07	**Care Transformation Collaborative of Rhode Island**
2.07.08	**Level IV Alcohol and Drug Detoxification Program**
2.07.09	**CurrentCare**
2.07.10	**Dental Services**
2.07.11	**All Payer Claims Database**

ARTICLE I: DEFINITIONS

2. **Section 1.02 ACCOUNTABLE ENTITY** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "An accountable entity is an integrated network consisting of an inter-disciplinary provider organization that is financially accountable for member cost, quality and health outcomes for Medicaid populations within value-based payment arrangements."

3. **New Section 1.03 ACTIVE CONTACT MANAGEMENT (ACM)** is amended by ***INSERTING*** the following new definition as follows, "**Active Contract Management (ACM)** is a set of strategies that applies high-frequency use of data and purposeful management of agency-service provider interactions to improve services of contract. ACM consists of the following elements: (1) Contractor to detect and rapidly respond to

problems; (2) Make consistent improvements to performance; and (3) Identify opportunities for reengineering service delivery systems. And renumbering subsequent subsections.

4. **Section 1.27, New Section 1.28 DEEMED NEWBORN ELIGIBILITY** is amended by ***INSERTING,*** the following new definition: **"Deemed Newborn Eligibility** – Babies born to Medicaid-eligible pregnant women who are residents of Rhode Island are deemed eligible from the date of birth. Once deemed eligible as a newborn, the infant remains eligible for one (1) year and, as such, is a non-MAGI eligibility pathway. Accordingly, retroactive coverage is available for periods prior to the application date, if the newborn was otherwise deemed eligible." And renumbering subsequent subsections.

5. **Section 1.28, New Section 1.29 DURABLE MEDICAL EQUIPMENT** is amended by ***DELETING*** the previous definition for **Durable Medical Equipment** and ***REPLACING*** it with the following, "Medical and appliances are items that are primarily and customarily used to serve medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. Items that had previously only been offered under sections HCBS 1915 (c) and HCBS 1915 (i) that will now be covered under the home health benefit (e.g. grab bars). https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html "

6. **New Section 1.81 NON-RISK PAYMENT,** is amended by inserting the following new definition as follows, "A type of risk mitigation strategy used to address uncertainty in rate development, a non-risk payment is a payment made to a managed care plan for specific, identifiable costs reimbursed outside of the capitation rate. This arrangement cedes complete risk for paying for certain services back to the state." And renumbering subsequent subsections.

7. **Section 1.82, New Section 1.84 PATIENT CENTERED MEDICAL HOME** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "A Patient-Centered Medical Home (PCMH) provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. To be recognized as a PCMH, a practice must meet the three-part definition established by the Office of the Health Insurance Commissioner (OHIC), which requires demonstration of practice transformation, implementation of cost management initiatives, and clinical improvement. Updated definitions, standards, quality measures, and an updated list of recognized practices can be found at the following link; http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php."

8. **Section 1.127, New Section 1.129 TOTAL COST OF CARE (TCOC)** is amended by ***DELETING*** the definition in its entirety and ***REPLACING*** it with the following, "Total cost of care (TCOC) is a fundamental element the Accountable Entity program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify

a potential shared savings or risk pool. Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics."

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

9. **Section 2.01.01 Alternative Payment Methodologies (APMs), Health System Transformation Project (HSTP), and Accountable Entities (AEs),** is hereby amended by changing the number in sentence three from 3,000 to 2,000 attributed lives.

   This section is further amended by ***DELETING*** the last sentence in its entirety.

   This section is further amended by the third sentence of the third paragraph to read as follows, "The second is promoting the development of EOHHS certified Accountable Entities that are inter-disciplinary in composition and practice, and focused on population health, with programs tailored to address varying levels and types of needs."

10. **Section 2.01.01.01 Alternative Payment Methodologies,** is hereby amended by ***DELETING*** paragraph six in its entirety.

    This section is further amended by ***DELETING*** the first sentence in paragraph eight.

    This section is further amended by ***DELETING*** the first and second sentences of paragraph nine and changing the new first sentence to read as follows, "EOHHS will review the Contractor's Accountable Entity contract to assure compliance with requirements before granting approval."

    This section is further amended by ***DELETING*** the words, "or sooner" after "January 1, 2018" in the first sentence of paragraph ten.

    Lastly, this section is amended by ***DELETING*** paragraph eleven in its entirety.

11. **Section 2.01.01.01.01 Capitation Withhold and Adjusting Payments** is hereby amended by ***REVISING*** the first sentence of paragraph two to read as follows, "The Contractor submissions to EOHHS for "Alternative Payment Methodology Reporting Template for Managed Care Organizations" will be done in accordance with timeline on reporting calendar."

12. **Section 2.01.01.02 Accountable Entities,** is hereby amended by ***DELETING*** the words, "the pilot phase and or the subsequently" from the first sentence of paragraph two.

    This section is further amended by ***DELETING*** the bulleted items after paragraph two in their entirety and ***REPLACING*** them with the following new bulleted items:

    - Attribution Requirements

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

13. **Section 2.05.02.01 Enrollment of Newborns Up to 250% of FPL,** is hereby amended by ***ADDING*** the following sentence to the end of paragraph two, "Contractor will adhere the Managed Care Newborn File Discrepancy Policy and Procedure dated January 27, 2020."

14. **Section 2.05.02.03 Enrollment of Uninsured Children up to Age Eighteen Above 250 Percent of the FPL (Related Group)**, is hereby amended by ***ADDING*** the following two paragraphs to the end of the section:

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

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

15. **Section 2.05.03 Change in Status,** is hereby amended by ***ADDING*** the following two paragraphs to the end of the section:

    "Contractor shall follow the EOHHS policy and procedures document titled, "EOHHS Medicaid Managed Care Organization (MCO) Requirements for Medicaid Member Demographic Changes."

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

16. **Section 2.05.10.01 Required Information,** is amended by ***INSERTING*** the following paragraph to the end of the section as follows:

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

    > (i) When appropriate Contractor must make available in electronic or paper form, the following information about its formulary:
    >
    > (1) Which medications are covered (both generic and name brand).
    >
    > What tier each medication is on.
    >
    > Formulary drug lists must be made available on the Contractor's Web site in a machine readable file and format as specified by the Secretary."

17. **Section 2.06.01.08 EPSDT,** is amended by ***REVISING*** paragraph one to read as follows, " The Contractor agrees to work with contracted providers to provide the full early and periodic screening, diagnosis, and treatment services to all eligible children, pregnant women, unborn children, and young adults up to age 21 in accordance with the *Rhode Island* EPSDT Periodicity Schedule, that assures that all EPSDT billable services are coded with established CPT/HCPC codes and submitted through the normal administrative claims processes as included in ATTACHMENT D or modified by EOHHS during the period of this Agreement."

    This section is further amended by ***INSERTING*** a bullet to the end of the **Screening** section as follows:

    - And provide EOHHS with a list of established CPT/HCPC codes used to identify all billable services included in the EPSDT schedule

    This section is further Amended is amended by correcting the reference to, "ATTACHMENT E" in paragraph one (1) and under the, "**Screening**" section, paragraph one (1) to; "ATTACHMENT D".

18. **Section 2.06.01.09 Enhanced Services,** is amended by ***INSERTING*** the following bullet to the end of the section labeled, **General Tracking, Follow-up and Outreach** as follows:

    - Work with contracted providers to assure compliance with EPSDT screening including: 1) Providers are identifying and submitting through the normal administrative claims processes and using the appropriate CPT/HCPC codes to track EPSDT services, 2) the fee schedule used to reimburse for services, and 3) assurance that the fee schedule is sufficient to incentivize providers to offer and submit the service in their normal billing cycle.

19. **Section 2.07.02 Non-Emergency Transportation,** is amended by ***REVISING*** the requirement in the last sentence from "quarterly" to "annually".

20. **Section 2.07.07 Care Transformation Collaborative of Rhode Island,** is amended by ***DELETING*** the language in its entirety and ***REPLAICNG*** it with the following new language, "The Contractor is required to participate both financially and operationally in the Care Transformation Collaborative of Rhode Island (CTC-RI), including Patient-Centered Medical Home for Kids (PCMH-Kids), according to the requirements for participation as set forth by EOHHS and consistent with parameters established by the CTC-RI Executive Committee. This participation will include, but not be limited to provision of high utilizer reports to participating practice sites, provider PMPM payments, CTC-RI administrative payments, and referrals to community health teams.

Reporting requirements for all providers shall follow OHIC procedures which can be found at the following link; http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php."

21. **Section 2.07.08 Level IV Alcohol and Drug Detoxification Program,** is amended by ***REPLACING*** the language in the section to read as follows, "For all members who are admitted to Level IV alcohol and drug detoxification programs, the Contractor is required to pay the negotiated per member per month rate, as documented in ATTACHMENT L, for Level IV alcohol and drug detoxification programs' case management."

22. **Section 2.08.02.01 EOHHS Certification of AEs,** is hereby amended by changing the word, "compliant" to "comply" in sentence three of the first paragraph.

    This section is further amended by ***DELETING*** the last sentence in the first paragraph and ***REPLACING*** it with the following, "The Contractor must submit on an annual basis the APM base Contract with highlighted modifications for the next AE program year for EOHHS review and approval."

23. **Section 2.08.02.02 Requirements for Contracting with EOHHS Certified AEs**, is hereby amended by ***DELETING*** the section in its entirety.

24. **Section 2.08.02.03, New Section Number 2.08.02.02 Operational Requirements for Management of APM Subcontracts with Accountable Entities,** is hereby amended by ***DELETING*** the second bullet under the first paragraph in its entirety and ***REPLACING*** it with the following, "Provision of Monthly Member Attribution. On a monthly basis, the Contractor will provide contracted AEs and EOHHS with electronic lists of attributed members, inclusive of identification of additions and deletions. Attribution will be based on the methodology set forth in '*RI EOHHS' Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners."*

    This section is further amended by ***ADDING*** a third bullet under the first paragraph as follows, "Provision of Monthly Provider Roster: On a monthly basis, the Contractor will provide EOHHS with electronic list of AE providers, inclusive of identification of additions and deletions."

    This section is further amended by ***DELETING*** in its entirety the first sentence of the fourth bullet under paragraph one and ***REPLACING*** it as follows, "*On a monthly basis, Contractor will provide AE with a full claims extract, including member specific utilization and cost data* to better enable AEs to examine and understand patterns of utilization by attributed members and develop plans of action."

    This section is further amended under section titled. "*Financial Reporting and Settlement with AEs"* as follows, ***DELETING*** the word, "may" and ***REPLACING*** it with the word, "will" in the first sentence of paragraph one.

    This section is further amended by ***DELETING*** the last sentence of paragraph one.

This section is further amended under section titled, "*Monitoring and reporting to EOHHS* by ***DELETING*** the last two bullets in the section in their entirety.

25. **Section 2.08.02.04, New Section 2.08.02.03 HSTP and the Medicaid Infrastructure Incentive Program,** is hereby amended by ***DELETING***, "total cost of care and attribution based" in the last sentence of paragraph three and ***REPLACING*** it with, "APM".

    This section is further amended by ***DELETING*** the words, "from time to time" from the second sentence in paragraph eight and ***REPLACING*** it with the word, "annually".

    This section is further amended under section titled, "*Structure of the Medicaid Infrastructure Incentive Program*" by ***DELETING*** the words, "three parts" in sentence two of paragraph one.

26. **Section 2.08.02.05, New Section 2.08.02.04 Development, Implementation, and Oversight of AEIP Program,** is hereby amended by ***ADDING*** the words, "& MCO Incentive Program Management Pool (MCO-IP) to the first sentence after the work, "AEIP" in second bullet under paragraph two.

    This section is further amended by ***ADDING*** the words, "and performance metrics" to the end of the last sentence in paragraph three.

    This section is further amended by ***DELETING*** the words, "MCO Incentive Program Management Pool" from the last sentence of paragraph four.

    This section is further amended by ***DELETING*** the second bullet titled, "Provide Guidance to the AEs to Submit HSTP AEIP Proposals and all subsequent sub-bullets in that section.

    This section is further amended by ***DELETING*** the third bullet entirely titled, "Review Current Certification Status with AE" and entire paragraph under third bullet.

    This section is further amended by ***DELETING*** the first sentence of paragraph one under bullet titled, "Provide a Comprehensive Analytic Profile of the AE's Attributed Population" and ***REVISING*** the new first sentence to read as follows, "The Contractor will work with each contracted AE to assist in the production of a population specific analysis of the AE's attributed population."

    This section is further amended by ***DELETING*** the last sentence of paragraph two under bullet titled, "Provide a Comprehensive Analytic Profile of the AE's Attributed Population" along with the entire next bullet titled, "Establish and Convene Contractor Review Committee for Evaluation of AE Proposals and Recommendations for Action".

This section is further amended by ***DELETING*** the words, "associated milestones" and ***REPLACING*** it with the word, "metrics" in the last sentence of paragraph one under Bullet titled, "Execute AEIP Incentive Contracts with Accountable Entities".

This section is further amended by ***DELETING*** paragraph two under Bullet titled, "Execute AEIP Incentive Contracts with Accountable Entities".

This section is further amended by ***DELETING*** the last sentence of paragraph three under bullet titled, "Execute AEIP Incentive Contracts with Accountable Entities", and ***REPLACING*** it as follows, "Incentive contracts will specify performance requirements and milestones to be achieved for AEs and MCOs to earn incentive payments as set forth in "RI EOHHS Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners".

This section is further amended by ***DELETING*** in the entirety the following language from paragraph three under bullet titled, "Execute AEIP Incentive Contracts with Accountable Entities" The Contract Amendment will:

- Incorporate the central elements of the approved AE submission, including:
  - Stipulation of program objective
  - Scope of activity to achieve
  - Performance schedule for milestones
  - Define a review process and timeline to evaluate AE progress in meeting milestones in its AEIP project plan and determine whether AE performance warrants incentive payments.
  - The Contractor must certify that an AE has met its approved milestones and metrics as a condition for the release of associated AEIP funds to the AE.

- Set Payment terms and schedule – specific activities and metrics selected for each AE assuring that basis for earning incentive payment(s) commensurate with the value and level of effort required and in accord with the allocation of incentive payments as set forth in the table below.
- Delineate responsibilities and define areas of collaboration between the AE and the Contractor. Areas of collaboration may be based on findings from the certification process and address such areas as health care data analytics in service utilization, developing and executing plans for performance improvement, quality measurement and management, and building care coordination and Care Management capabilities.
- Minimally require that AEs must submit quarterly reports to the Contractor using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive AEIP payments. Such reports will be shared directly by the Contractor with EOHHS.
- Stipulate that the AE must earn payments through demonstrated performance. The AE's failure to fully meet a performance milestone under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. no payment for partial fulfillment).

State that in the event that an AE fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AEIP payment), an AE can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.
Note: AE performance metrics in the "Fixed Percentage Allocations Based on Specific Achievements" category is specific to the performance period and must be met by the close of the performance year in order for an AE to earn the associated incentive payment.

- Note that all subcontracts are subject to the terms set forth in, Section 3.05.05 "Subcontracts and Delegation of Duty"."

This Section is further amended by ***REVISING*** bullet titled, "**Submit to EOHHS a Schedule of Projected Milestones and Payments for each AEIP"** to now read as follows, "**Submit to EOHHS a Schedule of Project Based Metrics and Payment for EOHHS Approval**

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

This section is further amended by ***REVISING*** the second sentence in the first sub-bullet under bullet title, "**Assess AE Performance to Determine Whether Incentive Payments Have Been Earned"** to read as follows to read as follow, "Contractor will review and evaluate AE progress in achieving AEIP performance targets and determine whether AE performance warrants incentive payments." This section is further amended by ***DELETING*** the second sub-bullet in its entirety.

27. **Section 2.08.02.05.01 Allocations of AEIP Incentive Opportunities within Subcontract with AE, AEIP Payments by EOHHS to the Contractor, and AEIP Payments by the Contractor to AE** is hereby amended as follows, ***ADDING*** the words, "and metrics" to the end of the second sentence in paragraph two.

This section is further amended by ***ADDING*** a fifth paragraph that will read as follows, "All EOHHS MCO and AE incentive payments will be made to the MCOs on a quarterly basis for achievement of milestones. Payment is made within 30 days for receipt of

completed MCO and AE Performance Milestone reports, including supporting documentation. MCOs must pay AEs within 30 days of receiving AE funds from EOHHS."

This section is further amended by ***DELETING*** the entire section for bullet titled, "Basis for AEIP Payments by the Contractor to the AE" in its entirety.

This section is further amended by ***REVISING*** paragraph one under bullet titled, "Maintain Separate Account for Each AEIP and Final Settle Up" as follows, ***DELETING*** the words, "Project Plan" in the second sentence after the word AEIP. ***ADDING*** the words, "and project-based metric" after the word, "milestone" in the second sentence. ***ADDING*** the words, "and project-based measure" after the word, "milestone" in sentence three.

This section is further amended by ***ADDING*** a new sentence after sentence one of paragraph three as follows, "Fixed Milestones are an exception to and must be met by close of the performance period for an AE to earn incentive funds."

This section is further amended by ***DELETING*** bullet titled, "Reporting to EOHHS" in its entirety and ***REPLACING*** it with the bulleted section as follows:

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

28. **Section 2.08.02.06 MCO Incentive Program Management Pool (MCO-IMP),** is here by amended as follows, ***DELETING*** paragraph two its entirety. ***DELETING*** the word, "summary" before the word, "report" in sentence one of paragraph five, and ***ADDING*** the words, "and metrics after the word, "milestone" in sentence one of paragraph five.

29. **Section 2.08.02.07 Operational Quality, and Financial Reporting for Accountable Entity Initiative,** is hereby amended **by** ***DELETING*** the words, "the Pilot AEs and/or" from sentence one, letter a), of paragraph two after the words, "an electronic list of".

30. **Section 2.08.16 Network Changes,** is hereby amended by ***REPLACING*** the last sentence of paragraph one to read as follows, "The Contractor agrees to follow policies and procedures contained in the attached Provider Terminations and Network Changes Policy V1.2".

This section is further amended by ***ADDING*** the following sentence to the end of the first paragraph, "Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State established provider-specific network adequacy standards."

31. **Section 2.10 Member Services,** is amended by ***ADDING*** the following language to the end of the section as follows,

    "Call Center Performance:

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

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

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

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

32. **Section 2.12.03.02.01, Drug Utilization Review,** is amended by ***INSERTING*** the following paragraph to the end of the section as follows, "Contractor is required to comply with RI General Assembly H-8313 Relating to Food and Drugs – Naloxone Access (2) Ensuring that opioid antagonists that are distributed in a non-pharmacy setting are eligible for reimbursement from any health insurance carrier, as defined under chapters 18, 19, 20, and 41 of title 27, and the Rhode Island medical assistance program, as defined under chapter 7.2 of title 42."

    This section is further amended by ***INSERTING*** the following two bullets to the end of paragraph two after the third bullet as follows:

    - Maximum daily morphine equivalent (MME) safety edits; and

- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

33. Section 2.12.03.03, Quality Assurance is hereby amended by ***ADDING*** a new paragraph six to read as follow, "The Contractor must contract with a state-approved vendor to ensure the appropriate and timely exchange of clinical data related to their quality performance i.e. HEDIS®."

This section is further amended by adding, "The following to the fourth paragraph after the first sentence, "Contractor will be required to attend monthly Oversight meetings with EOHHS staff to review contract performance, compliance, quality assurance, continuous quality improvement. As part of EOHHS' strategic efforts to move from reactive contract performance evaluation to active contracting monitoring and oversight, EOHHS has aligned vendor management efforts towards Active Contract Management (ACM) to meet the Managed Care Goals."

34. Section 2.13.10 title is amended to change "HIPPA" to "HIPAA".

35. Section 2.15.01 Acceptance of State Capitation Payments, is amended by ***INSERTING*** the following paragraph to the end of the section as follows:

"General Capitation Payments, as defined in Section 1.7, may only be made by the State and retained by the Contractor for managed care members eligible for Covered Services, in accordance with 42 CFR 438.3(c)(2).

In accordance with 42 CFR 438.3(c)(1)(i) Standard Contract Requirements concerning payments. The following requirements apply to the final capitation rate and the receipt of capitation payments under the contract: (1) The final capitation rate for each MCO, PIHP or PAHP must be specifically identified in the applicable contract submitted for CMS review and approval.

In accordance with 42 CFR 438.3(e)(1)(ii) the Contractor agrees that they shall cover for enrollees, services that are in addition to those covered under the State plan. Specifically, the Contractor agrees to cover such additional services that are necessary to comply with 42 CFR 438.910.

In accordance with 42 CFR 457.1201(c),(n)(2),(o),(p) Contractor agrees that State shall make the final capitation rates and payment in accordance with 42 CFR 438.3(c), 457.1207(o), 457.1240(b) (cross-referencing 42 CFR 438.330(b)(2), (b)(3), (c), and (e)) 457.1240(e) (cross-referencing 42 CFR 438.340) and 457.1250(a) (cross-referencing 42 CFR 438.350)."

36. Section 2.16.03 Financial Data Reporting, manual reference changed from Rhode Island Medicaid Managed Care Health Plan Financial Reporting Program to EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Reporting Penalties.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

37. **Section 3.04.04 Liability for Payment**, is amended to add the following language following bullet number three (3), "Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. EOHHS must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority."

38. **Section 3.07.04.03 Non-Compliance with Data Reporting Standards,** The last sentence will be changed to read as follow; "The Contractor is required to submit a report timely, accurately, in the correct template and/or with the proper naming convention and must remedy any error within three (3) business days of notification of the error form EOHHS."

39. **Section 3.10.05 Procedures on Termination,** is amended to add the following language to the end of the paragraph following bullet number four (4), "The transition of any and all data will be delivered at no cost and in a format determined by EOHHS."

ADDENDUM XII – BUSINESS ASSOCIATE AGREEMENT

40. Revise Attachment 1 title to read as follows:

"ATTACHMENT 1 TO BUSINESS ASSOCIATE AGREEMENT –

SOCIAL SECURITY DATA"

ATTACHMENT A: SCHEDULE OF IN-PLAN BENEFITS

41. Revision being made to section labeled EPSDT Services; Section 2.06.01.05 reference is incorrect and should be amended to Section 2.06.01.08. Also, the reference to ATTACHMENT should be "D" not "ED".

    Further revision being made to section labeled Nutrition Services; description should reference "ATTACHMENT E" **not** "ATTACHMENT D".

ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2021

42. This Attachment is amended by ***DELETING*** the Attachment in its entirety and ***REPLACING*** it with a new Attachment J dated July 1, 2020.

ATTACHMENT L: RATE-SETTING PROCESS

43. This Attachment is amended by ***DELETING*** the Attachment in its entirety and ***REPLACING*** it with a new Attachment L dated July1, 2020.

ATTACHMENT N: SPECIAL TERMS AND CONDITIONS

44. Section 5. MLR Reporting, is amended by ***ADDING,*** "42 CFR 438.8(i)" to the end of the first sentence.

This section is further amended by ***ADDING*** a new paragraph to the end of the section as follows:

> "The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting, in accordance with 42 CFR 438.8(k)(3)."

Further Amendment made to **Section 7, Payments to Certified Patient Centered Medical Homes**, is amended by ***DELETING*** the section in its entirety and ***REPLACING*** it with the following new language, "For all enrolled adult members whose medical home is a participating practice in the Rhode Island Care Transformation Collaborative (CTC), the Contractor shall pay the negotiated per member per month rate, quality incentive payments, and administrative component, as outlined in:
ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2021.

For all enrolled pediatric members whose medical home is (a) certified as a Patient Centered Medical Home, (b) a participating practice in the CTC or PCMH-Kids program, or (c) a graduate of the PCMH-Kids program, the Contractor shall pay the negotiated per member per month rate, quality incentive payments, and administrative component, as outlined in:
ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2021.

For practices that have graduated from PCMH-Kids and maintain OHIC PCMH recognition, the Contractor shall at a minimum adopt the following key components in alignment with those detailed in the CTC Pediatric Common Contract: care management payment, reports, performance incentive, and provider responsibilities. Rates for care management and quality incentive payments shall be made in accordance with:

ATTACHMENT J: CONTRACTOR'S CAPITATION RATES SFY 2021."

Further Amendment made to **Section 9, Stop-Loss Claiming** of this Attachment is amended by ***ADDING*** the following sentence to the end of the first paragraph, "EOHHS will reimburse the Contractor for Hepatitis C pharmacy expenditures up to one year from the date that the claim was incurred."

This section is further amended by ***ADDING*** the following sentence to the end of the second paragraph, "EOHHS will reimburse the Contractor for organ transplant claims up to one year from the date that the Contractor's Stop-Loss policy ends."

ATTACHMENT P: BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

45. Section 3 Mental Health Parity bullet number two in this section has a misspelled word "ae" has been changed to "are".

ATTACHEMENT Q: CARE MANAGEMENT PROTOCOLS FOR ALL MEMBERS

46. This Attachment is amended by ***DELETING*** the section references in **Section 2** and ***REPLACING*** them with only section names as follows:

Health Risk Assessment
Short Term Care Coordination
Intensive Care Management

ATTACHMENT U: CLAIMS BASED DATA ELEMENTS

47. This Attachment is amended by ***ADDING*** after the grid labeled, "Clam Based Data Elements", the following language: "Contractor is required to submit primary and any and all applicable diagnosis codes."

This Attachment is further amended by ***ADDING*** three field boxes after, "Admission Type" as follows:

Claimed Amount/Charges	Box 28	Box 47
Allowed Amount	Other	Other
Paid Amount	Other	Other

48. The Agreement is amended by ADDING, "ATTACHMENT V: COVID-19 PUBLIC HEALTH EMERGENCY"

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

STATE OF RHODE ISLAND:	**TUFTS HEALTH PUBLIC PLANS:**
Benjamin Shaffer (Digitally signed by Benjamin Shaffer DN: cn=Benjamin Shaffer, o=EOHHS, ou=RI Medicaid, email=benjamin.shaffer@ohhs.ri.gov, c=US Date: 2021.04.08 17:36:11 -04'00')	Jean Yang (Digitally signed by Jean Yang Date: 2021.04.08 13:10:55 -04'00')
SIGNATURE	SIGNATURE
BENJAMIN L. SHAFFER	Jean Yang
NAME	NAME
MEDICAID DIRECTOR	President
TITLE	TITLE
April 8, 2021	April 8, 2021
DATE	DATE

ATTACHMENT J

CONTRACTOR'S CAPITATION RATES SFY 2021

State of Rhode Island
Executive Office of Health and Human Services
State Fiscal Year 2021 Capitation Rate Development
Medicaid Managed Care Program
Tufts Health Public Plans
Rate Change Summary

Region: Statewide	SFY 2021 Effective Rate	Vaccine Assessment	Premium Tax	SFY 2021 Capitation Rate	Prior Capitation Rate	% Change	Withhold	SFY 2021 Net Capitation Rate	Baseline Medical Expense for Risk Corridor
RIte Care									
RC - MF<1	$ 626.75	$ 0.00	$ 12.79	$ 639.54	$ 582.84	9.7%	$ (3.20)	$ 636.34	$ 570.48
RC - MF 1-5	186.41	-	3.80	190.21	174.59	8.9%	(0.95)	189.26	169.78
RC - MF 6-14	173.30	-	3.54	176.84	165.39	6.9%	(0.88)	175.96	157.85
RC - M 15-44	236.40	1.68	4.86	242.94	237.00	2.5%	(1.21)	241.73	217.56
RC - F 15-44	391.68	2.55	8.05	402.28	370.14	8.7%	(2.01)	400.27	360.38
RC - MF 45+	557.23	3.18	11.44	571.85	540.31	5.8%	(2.86)	568.99	512.67
RC - EFP	20.03	-	0.41	20.44	16.41	24.6%	-	20.44	17.73
RC - SOBRA	13,037.80	-	266.08	13,303.88	12,469.27	6.7%	-	13,303.88	12,581.48
Subtotal RIte Care	**$ 311.50**	**$ 1.11**	**$ 6.38**	**$ 318.99**	**$ 297.00**	**7.4%**	**$ (1.44)**	**$ 317.55**	**$ 286.86**
Children with Special Healthcare Needs									
CSHCN - Adoption Subsidy	$ 621.83	$ 0.09	$ 12.69	$ 634.61	$ 543.13	16.8%	$ (3.17)	$ 631.44	$ 556.69
CSHCN - Katie Beckett	3,514.68	0.18	71.73	3,586.59	3,282.90	9.3%	(17.93)	3,568.66	3,216.05
CSHCN - SSI < 15	1,548.24	-	31.60	1,579.84	1,460.74	8.2%	(7.90)	1,571.94	1,416.78
CSHCN - SSI >= 15	1,196.20	1.48	24.44	1,222.12	1,029.66	18.7%	(6.11)	1,216.01	1,094.58
CSHCN - Substitute Care	830.43	0.75	16.96	848.14	743.92	14.0%	(4.24)	843.90	743.36
Subtotal Children with Special Healthcare	**$ 1,096.36**	**$ 0.52**	**$ 22.38**	**$ 1,119.26**	**$ 994.42**	**12.6%**	**$ (5.60)**	**$ 1,113.67**	**$ 995.99**
Medicaid Expansion									
ME - F 19-24	$ 312.41	$ 3.18	$ 6.44	$ 322.03	$ 265.40	21.3%	$ (1.61)	$ 320.42	$ 285.86
ME - F 25-29	448.13	3.18	9.21	460.52	415.08	10.9%	(2.30)	458.22	410.11
ME - F 30-39	669.02	3.18	13.72	685.92	580.33	18.2%	(3.43)	682.49	612.21
ME - F 40-49	873.16	3.18	17.88	894.22	758.70	17.9%	(4.47)	889.75	799.04
ME - F 50-64	811.01	3.18	16.62	830.81	725.72	14.5%	(4.15)	826.66	742.12
ME - M 19-24	213.36	3.18	4.42	220.96	204.67	8.0%	(1.10)	219.86	195.26
ME - M 25-29	398.20	3.18	8.19	409.57	360.06	13.8%	(2.05)	407.52	364.42
ME - M 30-39	587.41	3.18	12.05	602.64	538.93	11.8%	(3.01)	599.63	537.59
ME - M 40-49	768.78	3.18	15.75	787.71	735.51	7.1%	(3.94)	783.77	703.63
ME - M 50-64	861.85	3.18	17.65	882.68	820.73	7.5%	(4.41)	878.27	788.71
ME - SOBRA	13,037.80	-	266.08	13,303.88	12,469.27	6.7%	-	13,303.88	12,581.48
Subtotal Medicaid Expansion	**$ 606.15**	**$ 3.18**	**$ 12.43**	**$ 621.76**	**$ 553.88**	**12.3%**	**$ (3.06)**	**$ 618.70**	**$ 555.14**
Rhody Health Partners									
RHP - ID	$ 1,288.12	$ 3.18	$ 26.35	$ 1,317.65	$ 1,199.29	9.9%	$ (6.59)	$ 1,311.06	$ 1,191.53
RHP - SPMI	2,883.65	3.18	58.91	2,945.74	2,625.73	12.2%	(14.73)	2,931.01	2,667.76
RHP - Other Disabled 21-44	1,102.43	3.18	22.56	1,128.17	994.05	13.5%	(5.64)	1,122.53	1,019.82
RHP - Other Disabled 45+	1,744.12	3.18	35.66	1,782.96	1,592.92	11.9%	(8.91)	1,774.05	1,613.48
Subtotal Rhody Health Partners	**$ 1,762.01**	**$ 3.18**	**$ 36.02**	**$ 1,801.21**	**$ 1,606.02**	**12.2%**	**$ (9.00)**	**$ 1,792.21**	**$ 1,630.03**
Total	**$ 515.13**	**$ 1.86**	**$ 10.55**	**$ 527.54**	**$ 477.49**	**10.5%**	**$ (2.53)**	**$ 525.01**	**$ 473.31**

Note: Baseline medical expense for risk corridor reflects the sum of the base benefit expense, CTC adjustment, detoxification case management, and care coordination.

ATTACHMENT V

COVID-19 PUBLIC HEALTH EMERGENCY

On March 9, 2020, the Governor of the State of Rhode Island and Providence Plantations, declared a state of emergency due to the dangers to health and life posed by COVID-19.

On April 6, 2020, the Governor issued Executive Order 20-16 authorizing the Executive Office of Health and Human Services ("EOHHS") to seek Waiver and State Plan amendments from the Centers for Medicare and Medicaid and Medicare Services ("CMS") and adjustments to essential Medicaid provider rates. EOHHS has worked with CMS to obtain temporary Waiver and State Plan approval for changes to the provision of Medicaid services in Rhode Island during and in the immediate aftermath of the COVID-19 emergency.

The ("Contractor") is a licensed as a health maintenance organization by the Department of Business Regulation and contracts with EOHHS to provide services pursuant to Title XIX and Title XXI of the social security act to members as a Managed Care Organization.

The Contractor's members are amongst the most vulnerable of Rhode Island's citizens; and

As the number of presumptive and confirmed cases of COVID-19 continues to rise in Rhode Island and in our neighboring States, it is necessary to make temporary changes to the March 1, 2017 Agreement between the State of Rhode Island and Providence Plantations, Executive Office of Health and Human Services ("EOHHS") and the Contractor ("Agreement") to reflect and allow for the Waiver and State Plan changes to be fully implemented during the COVID-19 health crisis.

In consideration of the representations set forth herein, and the Contractor's vital role in ensuring the health and welfare of their members, the below temporary changes are hereby effective with this Amendment No. 4. The parties agree that this Attachment V shall remain in effect until such time as the Contractor shall receive written notification from EOHHS formally indicating that the requirements contained herein are no longer in effect. At which time the Contractor shall revert to the terms and conditions contained in the Agreement and previous the additional of Attachment V.

1. **PRE-AUTHORIZATION**
   The Contractor shall suspend the requirement for any pre-authorization of services required in the Agreement and as defined in Article 1.90. The Contractor shall also extend all existing pre-authorization of services for members. In addition, prior authorizations for medications shall be expanded by automatic renewal without clinical review, or time/quantity extensions. In the event of a drug shortage occurrence the Contractor shall cover a brand name drug product that is a multi-source drug if a generic drug option is not available.

2. **TELEMEDICINE**
   In accordance with the Governor's Executive Order 20-06 issued on March 18, 2020, the Contractor shall cover health services provided via telemedicine. This shall include

providers ordinarily excluded from telemedicine coverage fully taking into consideration all relevant factors relating to the immediate and critical need to reduce the spread of COVID-19 while also ensuring adequate member access and continuity of care. The Contractor shall not create or enforce any telemedicine coverage requirements or limitations based on the site at which either the patient of health provider is located at the time the health care services are delivered by means of telemedicine. The Contractor shall not impose nor enforce telemedicine coverage requirement limitations based solely on the patient's health status or diagnosis(es). Telemedicine services may be provided solely through audio or telephonic services if the Contractor determines that the provision of such audio only services is clinically appropriate. Telemedicine services must include real time interaction by a licensed provider capable of billing for such services. Contractors are authorized to liberally apply guidance from the Office of Civil Rights in the United States Department of Health and Human Services, dated March 17, 2020, regarding the temporary waiver of penalties for the Health Insurance Portability and Accountability Act violations against health care providers who serve patients through everyday communication technologies during the COVID-19 emergency, to deliver synchronous audio-visual services to ensure that more common methods are employable in the delivery of telemedicine services. The Contractor shall encourage providers to ensure that appropriate privacy and security is in place during the provision of telemedicine services. The Contractor shall follow all policies and procedures contained within the, "**COVID-19 TeleHealth Preventive Care Delivery Guidance for RI Medicaid"** which has been issued to support implementation of Governor Raimondo's March 18, 2020 Executive Orders.

The Contractor shall present clear communication materials to providers to explain how to submit claims of reimbursement for services provided via telemedicine/telehealth. The Contractor is permitted to require providers to present documentation of the substance provider-patient encounter for the encounter to qualify for reimbursement.

3. APPEALS AND GRIEVANCES

The Contractor shall extend the time frame and timelines in which a member can request a fair hearing or file a grievance to more than one hundred and twenty-one (120) days. Members shall continue to be authorized to immediately proceed to a state fair hearing. The Contractor is encouraged to resolve any request for a fair hearing to ensure that members maintain and receive covered services through the COVID-19 emergency.

4. OUT OF STATE PROVIDER REIMBURSEMENT

The Contractor is authorized to reimburse providers located out of state for emergency services provided to members.

5. COVID VACCINE

The Contractor is required to support any Federal and State requirements around vaccinations for COVID-19. Contractor agrees to be paid a non-risk payment for the administration of an approved COVID-19 vaccine in an amount equal to the State's fee-for-service fee schedule. Contractor agrees to pay COVID-19 vaccine providers the specified rate for COVID vaccine administration and submit required documentation for non-risk payment reimbursement by EOHHS.