

UHC 2017-03

CONTRACT BETWEEN

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

UNITEDHEALTHCARE OF NEW ENGLAND

FOR MEDICAID MANAGED CARE SERVICES

AMENDED JULY 1, 2019

TABLE OF CONTENTS

ARTICLE I: DEFINITIONS	16
1.01 ABUSE	16
1.02 ACCOUNTABLE ENTITY	16
1.03 ACTUARY	16
1.04 ADVANCED DIRECTIVE	16
1.05 ADVANCED PRACTICE PRACTITIONERS	16
1.06 ADVERSE BENEFIT DETERMINATION	17
1.07 AFFORDABLE CARE ACT	17
1.08 AFFORDABLE CARE ACT ELIGIBLES	17
1.09 AGREEMENT OR CONTRACT	17
1.10 APPEAL	18
1.11 CAPITATION PAYMENT	18
1.12 CARE COORDINATION	18
1.13 CARE MANAGEMENT	18
1.14 CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND (CTC-RI)	18
1.15 CASE MANAGEMENT	19
1.16 CHILDREN WITH SPECIAL HEALTH CARE NEEDS	19
1.17 CHOICE COUNSELING	19
1.18 CMS	19
1.19 COLD CALL MARKETING	19
1.20 COMMUNITY HEALTH TEAM	20
1.21 COMPREHENSIVE RISK CONTRACT	20
1.22 CONTRACT SERVICES	20
1.23 CONTRACTOR	20

1.24	CO-PAYMENT	20
1.25	COVERED SERVICES	20
1.26	DAYS	20
1.27	DURABLE MEDICAL EQUIPMENT	20
1.28	EMERGENCY DENTAL CONDITION	21
1.29	EMERGENCY MEDICAL CONDITION	21
1.30	EMERGENCY MEDICAL SERVICES	21
1.31	EMERGENCY MEDICAL TRANSPORTATION	21
1.32	EMERGENCY ROOM CARE	21
1.33	EMERGENCY SERVICES	21
1.34	EMERGENCY SERVICES/EMERGENCY MEDICAL CONDITION	22
1.35	ENROLLEE	22
1.36	ENROLLEE ENCOUNTER DATA	22
1.37	EPSDT	22
1.38	ESSENTIAL COMMUNITY PROVIDER	22
1.39	EXCLUDED SERVICES	22
1.40	EXECUTIVE OFFICE	23
1.41	FAMILY	23
1.42	FRAUD	23
1.43	GRIEVANCE	23
1.44	HABILITATION SERVICES	23
1.45	HEALTH CARE ACQUIRED CONDITIONS	23
1.46	HEALTH CARE PROFESSIONAL	23
1.47	HEALTH HOME	24
1.48	HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH) ACT	24
1.49	HEALTH INSURANCE	24
1.50	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)	24

1.51	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE	24
1.52	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SECURITY RULE	25
1.53	HEALTH PLAN, PLAN, OR HMO	25
1.54	HEALTH RISK ASSESSMENT	25
1.55	HOME CARE SERVICES	25
1.56	HOME HEALTH CARE	26
1.57	HOME HEALTH SERVICES	26
1.58	HOSPICE SERVICES	26
1.59	HOSPITALIZATION	26
1.60	HOSPITAL OUTPATIENT CARE	26
1.61	HOUSING STABILIZATION PROGRAM	26
1.62	IBNR (INCURRED BUT NOT REPORTED)	27
1.63	INCENTIVE PAYMENTS	27
1.64	INDIAN	27
1.65	INDIAN PROVIDER, SERVICE, INCLUDING CHCs OPERATED BY THE INS OR BY AN INDIAN TRIBE/ORGANIZATION, OR URBAN INDIAN ORGANIZATION	27
1.66	INTENSIVE CARE MANAGEMENT PLAN	27
1.67	LIMITED ENGLISH PROFICIENT (LEP)	27
1.68	LONG-TERM SERVICES AND SUPPORT	28
1.69	MARKETING	28
1.70	MARKETING MATERIAL	28
1.71	MATERIAL ADJUSTMENT	28
1.72	MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE	28
1.73	MEMBER OR MEDICAID MANAGED CARE MEMBER	29
1.74	MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)	29
1.75	NETWORK	29
1.76	NETWORK PROVIDER	29

1.77	NON-PARTICIPATING PHYSICIAN	29
1.78	NON-PARTICIPATING PROVIDER	29
1.79	OVERPAYMENT	29
1.80	PARTICIPATING PROVIDER	30
1.81	PARTY	30
1.82	PATIENT CENTERED MEDICAL HOME	30
1.83	PEER NAVIGATOR	30
1.84	PHYSICIAN SERVICES	31
1.85	PLAN	31
1.86	PLAN OF CARE	31
1.87	PLAN PHYSICIAN OR PARTICIPATING PHYSICIAN	31
1.88	POST-STABILIZATION CARE SERVICES	31
1.89	POTENTIAL ENROLLEE	31
1.90	PRE-AUTHORIZATION	31
1.91	PREMIUM	32
1.92	PREPAID BENEFIT PACKAGE	32
1.93	PREPAID INPATIENT HEALTH PLAN	32
1.94	PRESCRIPTION DRUG COVERAGE	32
1.95	PRESCRIPTION DRUGS	32
1.96	PREVALENT	32
1.97	PRIMARY CARE	32
1.98	PRIMARY CARE PHYSICIAN (PCP)	33
1.99	PRIMARY CARE PROVIDER (PCP)	33
1.100	PRIVATE DUTY NURSING	33
1.101	PROVIDER	33
1.102	PROVIDER PREVENTABLE CONDITIONS	33
1.103	RATE CELL	34

1.104	RATING PERIOD	34
1.105	READILY ACCESSIBLE	34
1.106	REHABILITATION SERVICES	34
1.107	RELATED GROUPS	34
1.108	RHODY HEALTH PARTNERS	35
1.109	RHODY HEALTH PARTNERS ELIGIBLE	35
1.110	RISK CONTRACT	35
1.111	RISK CORRIDOR	35
1.112	RITE CARE	35
1.113	RITE CARE ELIGIBLES	35
1.114	RITE SHARE	35
1.115	RITE SHARE MEMBER	36
1.116	SHORT-TERM CARE MANAGEMENT	36
1.117	SIBLING	36
1.118	SKILLED NURSING CARE AND SKILLED CARE SERVICES	36
1.119	SPECIALIST	36
1.120	SSI	36
1.121	STABILIZED	36
1.122	STATE	37
1.123	STOP LOSS	37
1.124	SUBCONTRACTOR	37
1.125	SUSPENSION	37
1.126	TELEHEALTH	37
1.127	TOTAL COST OF CARE (TCOC)	37
1.128	UNINSURED	38
1.129	URGENT CARE	38
1.130	URGENT MEDICAL CONDITION	38

1.131	WITHHOLD ARRANGEMENT	38
	ARTICLE II: HEALTH PLAN PROGRAM STANDARDS	39
2.01	GENERAL	39
2.01.01	Alternative Payment Methodologies (APMs), Health System Transformation Project (HSTP), and Accountable Entities (AEs)	40
2.02	LICENSURE and ACCREDITATION	44
2.03	HEALTH PLAN ADMINISTRATION	45
2.03.01	Executive Management	45
2.03.02	Other Administrative Components	45
2.03.03	RI Works Participants	46
2.03.04	Contract Readiness Review Requirements	46
2.04	ELIGIBILITY AND PROGRAM ENROLLMENT	48
2.04.01	Rite Care Eligible Groups	48
2.04.02	Rite Care Health Plan Lock-In	50
2.04.03	Rite Care Guaranteed Eligibility	50
2.04.04	Rhody Health Partners Eligible Groups	50
2.04.05	Rhody Health Partners Eligible Determination	50
2.04.06	Rhody Health Partners Guaranteed Eligibility	50
2.04.07	Rhody Health Partners Health Plan Lock-In	51
2.04.08	Affordable Care Act Eligible Population	51
2.04.09	New Eligibility Groups	51
2.04.10	Non-Biased Enrollment Counseling	51
2.04.11	Voluntary Selection of Health Plan by Members	52
2.04.12	Automatic Assignment to Health Plans	52
2.04.13	Automatic Re-Assignment Following Resumption of Eligibility	52
2.05	MEMBER ENROLLMENT AND DISENROLLMENT	53
2.05.01	Health Plan Marketing	53
2.05.02	Health Plan Enrollment Procedures	55
2.05.03	Change in Status	56
2.05.04	Enrollment and Disenrollment Updates	57
2.05.05	Services for New Members	57
2.05.06	New Member Orientation	57
2.05.07	Assignment of Primary Care Providers (PCPs)	58
2.05.08	Changing PCPs	59
2.05.09	Identification Cards	59
2.05.10	Member Handbook and Initial New Member Materials	60
2.05.11	Transitioning Members between Plans	66
2.05.12	Member Disenrollment	67
2.06	IN-PLAN SERVICES	70
2.06.01	Description of Comprehensive Benefit Package	70
2.06.02	Enrollee/Provider Communication	80
2.06.03	Second Opinion	81
2.06.04	New In-Plan Services and In-Plan Service Coverage Arrangements	81
2.06.05	Care Management and Care Coordination	81

2.07	COORDINATION WITH OUT-OF-PLAN SERVICES AND OTHER HEALTH/ SOCIAL SERVICES AVAILABLE TO MEMBERS	85
2.07.01	General	85
2.07.02	Special Education	86
2.07.03	Department of Behavioral Health, Developmental Disabilities and Hospitals	86
2.07.04	Rhode Island Department of Human Services	86
2.07.05	Rhode Island Department of Health	87
2.07.06	Care Transformation Collaborative of Rhode Island	88
2.07.07	Level IV Alcohol and Drug Detoxification Program	88
2.07.08	CurrentCare	88
2.07.09	Dental Services	89
2.07.10	Non-Emergency Transportation	Error! Bookmark not defined.
2.07.11	All Payer Claims Database	89
2.08	PROVIDER NETWORKS	89
2.08.01	Network Composition	89
2.08.02	Contracting with EOHHS Certified Accountable Entities	92
2.08.03	Primary Care Providers (PCPs)	105
2.08.04	Behavioral Health and Substance Use Disorder Providers	109
2.08.05	Substance Use Providers	109
2.08.06	Children's Behavioral Health Services	110
2.08.07	Physician/Provider Specialists	111
2.08.08	Electronic Visit Verification (EVV)	111
2.08.09	FQHCs/RHCs	111
2.08.10	Department of Health Laboratory	112
2.08.11	Title X Providers	112
2.08.12	School-Based Clinics	112
2.08.13	Mainstreaming	112
2.08.14	Selective Contracting	113
2.08.15	Provider Network Lists	113
2.08.16	Network Changes	113
2.08.17	Provider Discrimination	114
2.08.18	Networks Related to Indians	114
2.09	SERVICE ACCESSIBILITY STANDARDS	114
2.09.01	Twenty-Four Hour Coverage	114
2.09.02	Travel Time	115
2.09.03	Emergency Medical Services	116
2.09.04	Appointment Availability	117
2.09.05	Post-Stabilization Care Services	117
2.09.06	Access for Women	118
2.09.07	Assessment Standards	118
2.09.08	Health Risk Assessments	118
2.09.09	Access for Members with Special Needs	118
2.09.10	EOHHS Affordability Standards	119
2.09.11	High Utilizers	119
2.10	MEMBER SERVICES	119
2.10.01	General	119
2.10.02	Toll-Free Telephone Number	120
2.10.03	Annual Notification	121
2.10.04	Cultural Competency	122

2.11	PROVIDER SERVICES	123
2.11.1	Provider Manual	124
2.12	MEDICAL MANAGEMENT AND QUALITY ASSURANCE	124
2.12.01	General	124
2.12.02	Medical Director's Office	125
2.12.03	Utilization Review and Quality Assurance (UR/QA)	127
2.12.04	Care Transitions	133
2.12.05	Provider Credentialing	133
2.13	OPERATIONAL DATA REPORTING	134
2.13.01	General	134
2.13.02	Encounter Data Reporting	136
2.13.03	Grievance and Appeals Data	138
2.13.04	EOHHS Quality Assurance Data	138
2.13.05	Member Satisfaction Report	139
2.13.06	Provider Satisfaction Report	139
2.13.07	Fraud and Abuse Reports	139
2.13.08	Rite Share Reporting	140
2.13.09	Presentation of Findings	140
2.13.10	Health Insurance Portability and Accountability Act Requirements (HIPPA)	140
2.13.11	Certification of Data	141
2.13.12	Patient Protection and Affordable Care Act	141
2.13.13	All Payer Claims Database	141
2.14	GRIEVANCE AND APPEALS	141
2.14.01	General	142
2.14.02	Adverse Benefit Determination	142
2.14.03	Health Plan Grievance and Appeals Process	144
2.14.04	Expedited Resolution of Appeals	146
2.14.05	Continuation of Benefits	147
2.14.06	State Fair Hearing and External Appeal (Medical Review Process)	148
2.15	PAYMENTS TO AND FROM PLANS	149
2.15.01	Acceptance of State Capitation Payments	149
2.15.02	Cost Sharing	157
2.15.03	Stop Loss	158
2.15.04	Third-Party Liability	158
2.15.05	Reinsurance	158
2.15.06	Reserving	159
2.15.07	Claims Processing and MIS	159
2.15.08	Audits	159
2.15.09	Disproportionate Share Payments to Hospitals	160
2.15.10	Performance Goals	160
2.15.11	Prohibited Payments	160
2.16	HEALTH PLAN FISCAL STANDARDS	161
2.16.01	General	161
2.16.02	Financial Benchmarks	161
2.16.03	Financial Data Reporting	161
2.16.04	Audit	162

2.17	RECORDS RETENTION	163
2.17.01	General	163
2.17.02	Operational Data Reports	163
2.17.03	Medical Records	163
2.18	COMPLIANCE	164
2.18.01	General Requirements	164
2.18.02	Prohibited Affiliations with Individuals Debarred by Federal Agencies	165
2.18.03	Disclosure of the Contractor's Ownership and Control Interest	165
2.18.04	Disclosure by Providers: Information on Ownership and Control	167
2.18.05	Disclosure by Providers: Information Related to Business Transactions	168
2.18.06	Disclosure by Providers: Information on Persons Convicted of Crimes	168
2.18.07	Disclosures Made by Providers to the Contractor	169
2.18.08	Compliance with all Rhode Island Regulations	171
2.18.09	Compliance with all Federal Regulations	171
	ARTICLE III: CONTRACT TERMS AND CONDITIONS	172
3.01	GENERAL PROVISIONS	172
3.01.01	Contract Composition and Order of Precedence	172
3.01.02	Integration Clause	172
3.01.03	Subsequent Conditions	173
3.01.04	Effective Date and Term	173
3.01.05	Contract Administration	173
3.01.06	Contract Officers	173
3.01.07	Liaisons	174
3.01.08	Notification of Administrative Changes	174
3.01.09	Notices	174
3.01.10	Authority	174
3.01.11	Federal Approval of Contract	175
3.01.12	Special Terms and Conditions	175
3.02	INTERPRETATIONS AND DISPUTES	175
3.02.01	Conformance with State and Federal Regulations	175
3.02.02	Waivers	175
3.02.03	Severability	176
3.02.04	Jurisdiction	176
3.02.05	Disputes	176
3.03	CONTRACT AMENDMENTS	177
3.03.01	General	177
3.04	PAYMENT	178
3.04.01	Capitation Payments	178
3.04.02	Fee-For-Service Payments	179
3.04.03	Payments to Subcontractors and Providers	179
3.04.04	Liability for Payment	179
3.04.05	Payments for Health System Transformation Project Incentives	179
3.04.06	Payments for Federal Qualified Health Centers (FQHCs) and Rural health Centers (RHCs)	179
3.05	GUARANTEES, WARRANTIES, AND CERTIFICATIONS	180
3.05.01	Contractor Certification of Truthfulness	180

3.05.02	Contractor Certification of Legality	180
3.05.03	Contractor Certification of HMO Licensure	180
3.05.04	Performance Bond or Substitutes	181
3.05.05	Subcontracts and Delegation of Duty	181
3.05.06	Assignment of the Contract	184
3.05.07	Hold Harmless	184
3.05.08	Insurance	185
3.05.09	Force Majeure	187
3.05.10	Patent or Copyright Infringement	187
3.05.11	Clinical Laboratory Improvement Amendments (CLIA) Of 1988	187
3.05.12	Sterilization, Hysterectomy, and Abortion Procedures	188
3.05.13	Payments to Institutions or Entities Located Outside of the U.S.	188
3.06	PERSONNEL	188
3.06.01	Employment Practices	188
3.06.02	Employment of State Personnel	190
3.06.03	Independent Capacity of Contractor Personnel	191
3.07	PERFORMANCE STANDARDS AND DAMAGES	191
3.07.01	Performance Standards for Medicaid Managed Care	191
3.07.02	Suspension of New Enrollment	191
3.07.03	Fraud and Abuse	192
3.07.04	Damages	197
3.07.05	Deduction of Damages from Payments	201
3.07.06	Payments Denied by CMS	201
3.07.07	Intermediate Sanctions	202
3.07.08	COMPLIANCE AUDIT AND CORRECTIVE ACTION	203
3.08	INSPECTION OF WORK PERFORMED	203
3.08.01	Access to Information	203
3.08.02	Inspection of Premises	204
3.08.03	Approval of Written Materials	204
3.09	CONFIDENTIALITY OF INFORMATION	204
3.09.01	Maintain Confidentiality of Information	204
3.09.02	Confidentiality of Information	207
3.09.03	Assurance of Security and Confidentiality	209
3.09.04	Return of Confidential Data	209
3.09.05	Hold Harmless	209
3.09.06	State Assurance of Confidentiality	209
3.09.07	Publicizing Safeguarding Requirements	210
3.09.08	Types of Information to Be Safeguarded	210
3.09.09	Confidentiality and Protection of Public Health Information and Related Data	210
3.10	TERMINATION OF THE CONTRACT	211
3.10.01	Termination for Default	212
3.10.02	Termination for Unavailability of Funds	213
3.10.03	Termination for Financial Instability	213
3.10.04	Termination for Convenience	214
3.10.05	Procedures on Termination	214
3.10.06	Refunds of Advance Payments	215
3.10.07	Liability for Medical Claims	215

3.10.08	Termination Claims	215
3.10.09	Notification of members	216
3.10.10	Non-Compete Covenant	216
3.11	OTHER CONTRACT TERMS AND CONDITIONS	216
3.11.01	Environmental Protection	216
3.11.02	Ownership of Data and Reports	216
3.11.03	Publicity	217
3.11.04	Award of Related Contracts	217
3.11.05	Conflict of Interest	217
3.11.06	Reporting of Political Contributions	217
3.11.07	Environmental Tobacco Smoke	218
3.11.08	Titles Not Controlling	218
3.11.09	Other Contracts	218
3.11.10	Counterparts	218
3.11.11	Administrative Procedures Not Covered	218
ADDENDUM I		220
FISCAL ASSURANCES		220
ADDENDUM II		222
NOTICE TO EOHHS CONTRACTORS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964		222
ADDENDUM III		224
NOTICE TO EOHHS' CONTRACTORS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973		224
ADDENDUM IV		227
DRUG-FREE WORKPLACE POLICY		227
ADDENDUM V		229
DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE		229
ADDENDUM VI		230
SUBCONTRACTOR COMPLIANCE		230
ADDENDUM VII		231
CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE		231

ADDENDUM VIII	232
INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS	232
ADDENDUM IX	234
CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS	234
ADDENDUM X	235
CERTIFICATION REGARDING LOBBYING	235
ADDENDUM XI	237
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS SUPPLEMENTAL TERMS AND CONDITIONS FOR CONTRACTS AND SUBAWARDS FUNDED IN WHOLE OR IN PART BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, PUB. L. NO. 111-5	237
ADDENDUM XII	244
BUSINESS ASSOCIATE AGREEMENT	244
ADDENDUM XIII	258
REQUEST FOR PROPOSAL SCOPE OF WORK	258
ADDENDUM XIV	259
BUDGET	259
ADDENDUM XV	260
FEDERAL SUBAWARD REPORTING	260
ADDENDUM XVI	261
LIQUIDATED DAMAGES	261
ADDENDUM XVII	263
EQUAL EMPLOYMENT OPPORTUNITY	263
ADDENDUM XVIII	265

BID PROPOSAL	265
ADDENDUM XIX	266
CORE STAFF	266
ATTACHMENT A	267
SCHEDULE OF IN-PLAN BENEFITS	267
ATTACHMENT B	282
SCHEDULE OF OUT-OF-PLAN BENEFITS	282
ATTACHMENT C	284
SCHEDULE OF NON-COVERED SERVICES	284
ATTACHMENT D	286
RHODE ISLAND EPSDT PERIODICITY SCHEDULE	286
ATTACHMENT E	289
RHODE ISLAND NUTRITION STANDARDS	289
ATTACHMENT F	296
EXTENDED FAMILY PLANNING PROGRAM	296
ATTACHMENT G	300
FQHC AND RHC SERVICES	300
ATTACHMENT I	304
CONTRACTOR'S LOCATIONS	304
ATTACHMENT K	307
CONTRACTOR'S INSURANCE CERTIFICATES	307
ATTACHMENT L	308
MEDICARE-MEDICAID PLAN CAPITATION RATE CERTIFICATION AND CAPITATION RATES	Error! Bookmark not

defined.

ATTACHMENT N	310
SPECIAL TERMS & CONDITIONS	310
ATTACHMENT O	321
MENTAL HEALTH, SUBSTANCE USE AND DEVELOPMENTAL DISABILITY SERVICES FOR CHILDREN	321
ATTACHMENT P	341
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS	341
ATTACHMENT Q	380
CARE MANAGEMENT PROTOCOLS FOR ALL MEMBERS	380
ATTACHMENT U	391
CLAIMS BASED DATA ELEMENTS	391
INDEX	394

GENERAL PROVISIONS

This Agreement, including the attachments, hereto, is made and entered into effective July 1, 2019, between the Rhode Island Executive Office of Health and Human Services (referred to as "EOHHS", or "Executive Office", or the "State" in this Agreement) and UnitedHealthcare of New England (the "Contractor"). This Agreement ("Agreement") is entered into in conformity with EOHHS procedures.

ARTICLE I: DEFINITIONS

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

1.01 ABUSE

Abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

1.02 ACCOUNTABLE ENTITY

An accountable entity is an integrated multi-disciplinary entity certified by EOHHS capable of providing superior health outcomes for Medicaid populations within value-based payment arrangements.

1.03 ACTUARY

An actuary is an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

1.04 ADVANCED DIRECTIVE

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

1.05 ADVANCED PRACTICE PRACTITIONERS

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

1.06 ADVERSE BENEFIT DETERMINATION

Adverse benefit determination means, any of the following: (1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, (2) the reduction, suspension, or termination of a previously authorized service, (3) the denial, in whole or in part, of payment for a service, (4) the failure to provide services in a timely manner, as defined by the State, (5) the failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals, (6) for a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network, (7) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

1.07 AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act and the Health Care and Reconciliation Act of 2010 are commonly referred to as the Affordable Care Act (ACA). ACA is intended to improve the healthcare system and provide affordable quality of care to all Americans, lowering the uninsured rate by expanding public and private insurance coverage, and reduce the cost of care for individuals and government through a variety of measures. ACA requires businesses with more than fifty employees to provide health insurance to full-time employees and requires individuals to purchase health insurance. Subsidies are available to those who cannot afford health insurance. ACA establishes Affordable Insurance Exchanges to enable employers and individuals to purchase health insurance through a competitive market place. ACA prevents insurance companies from denying coverage to those with pre-existing conditions, eliminating life-time limits on benefits, and allow young adults up to twenty-six (26) years old to remain on their parent's insurance policy.

1.08 AFFORDABLE CARE ACT ELIGIBLES

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

1.09 AGREEMENT OR CONTRACT

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

1.10 APPEAL

A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or administrative action.

1.11 CAPITATION PAYMENT

Capitation Payment means a payment for each premium rate category EOHHS makes periodically to the Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State plan. EOHHS makes the payment regardless of whether the particular member receives services during the period covered by the payment.

1.12 CARE COORDINATION

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

1.13 CARE MANAGEMENT

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

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

The Care Transformation Collaborative of Rhode Island (CTC-RI) promotes the patient-centered medical home model of care throughout the State of Rhode Island. CTC-RI is coordinating this work with all major health care stakeholders in the state, believing that the Patient-Centered Medical Home (PCMH) model will improve care, so that it is available at a lower cost, with better health outcomes for Rhode Islanders.

1.15 CASE MANAGEMENT

Case management, a component of care management, is a set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.

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

1.16 CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

1.17 CHOICE COUNSELING

Choice counseling is information and services designed to assist beneficiaries in making enrollment decisions,

1.18 CMS

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

1.19 COLD CALL MARKETING

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

1.20 COMMUNITY HEALTH TEAM

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

1.21 COMPREHENSIVE RISK CONTRACT

Risk contract means an agreement under which the Contractor assumes financial risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the agreement.

1.22 CONTRACT SERVICES

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

1.23 CONTRACTOR

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

1.24 CO-PAYMENT

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

1.25 COVERED SERVICES

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

1.26 DAYS

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

1.27 DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses.

1.28 EMERGENCY DENTAL CONDITION

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

1.29 EMERGENCY MEDICAL CONDITION

A condition presenting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.

1.30 EMERGENCY MEDICAL SERVICES

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

1.31 EMERGENCY MEDICAL TRANSPORTATION

Ambulance services for an emergency medical condition.

1.32 EMERGENCY ROOM CARE

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

1.33 EMERGENCY SERVICES

Emergency services are organizations/providers who ensure public safety and health by dealing with types of emergencies. Some of these agencies exist solely for addressing certain types of emergencies while others deal with ad hoc emergencies as part of their normal responsibilities. Many of these agencies engage in community awareness and prevention programs to help the public avoid, detect, and report emergencies effectively.

1.34 EMERGENCY SERVICES/EMERGENCY MEDICAL CONDITION

Emergency Services means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) 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; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.35 ENROLLEE

A Medicaid beneficiary/recipient currently enrolled in a Medicaid Managed Care plan. For purposes of this Agreement, see definition of member.

1.36 ENROLLEE ENCOUNTER DATA

Enrollee encounter data is information relating to the receipt of any item or services by the enrollee under this contract.

1.37 EPSDT

EPSDT means Early and Periodic Screening, Diagnosis and Treatment, a comprehensive set of services provided to all Medicaid-eligible children under age 21.

1.38 ESSENTIAL COMMUNITY PROVIDER

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

1.39 EXCLUDED SERVICES

Health care services that your health insurance or plan does not pay for or cover.

1.40 EXECUTIVE OFFICE

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

1.41 FAMILY

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

1.42 FRAUD

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. Includes any act that constitutes fraud under State or Federal Law.

1.43 GRIEVANCE

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

1.44 HABILITATION SERVICES

Health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

1.45 HEALTH CARE ACQUIRED CONDITIONS

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

1.46 HEALTH CARE PROFESSIONAL

Health Care Professional means a physician or any of the following: a podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy assistant.

1.47 HEALTH HOME

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

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

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

1.49 HEALTH INSURANCE

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

1.50 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

1.51 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes

national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

1.52 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SECURITY RULE

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

1.53 HEALTH PLAN, PLAN, OR HMO

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

1.54 HEALTH RISK ASSESSMENT

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

1.55 HOME CARE SERVICES

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

1.56 HOME HEALTH CARE

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

1.57 HOME HEALTH SERVICES

Home Health Services means those services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy and speech-language pathology, as ordered by a health plan physician and provided by a Medicare-certified home health agency. This service also includes medical social services, other services, durable medical equipment and medical supplies for use at home. Home health services do not include respite care, relief care, or day care.

1.58 HOSPICE SERVICES

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

1.59 HOSPITALIZATION

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

1.60 HOSPITAL OUTPATIENT CARE

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

1.61 HOUSING STABILIZATION PROGRAM

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

1.62 IBNR (INCURRED BUT NOT REPORTED)

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

1.63 INCENTIVE PAYMENTS

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

1.64 INDIAN

Indian means an individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

1.65 INDIAN PROVIDER, SERVICE, INCLUDING CHCS OPERATED BY THE INS OR BY AN INDIAN TRIBE/ORGANIZATION, OR URBAN INDIAN ORGANIZATION

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

1.66 INTENSIVE CARE MANAGEMENT PLAN

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

1.67 LIMITED ENGLISH PROFICIENT (LEP)

Limited English proficient means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.68 LONG-TERM SERVICES AND SUPPORT

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

1.69 MARKETING

Marketing means any communication, from the Contractor to a Medicaid recipient who is not enrolled in Medicaid Managed Care or the Contractor that can reasonably be interpreted as intended to influence the recipient to enroll in Medicaid Managed Care.

1.70 MARKETING MATERIAL

Marketing material means materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to influence potential enrollees to change health plans.

1.71 MATERIAL ADJUSTMENT

Material adjustment is an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

1.72 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE

The term “medical necessity”, “medically necessary”, or “medically necessary service” means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms including such services necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. Medically necessary services must be provided in the most cost effective and appropriate setting and will not be provided solely for the convenience of the member or service provider. The authorization process for medically necessary services can be no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures.

1.73 MEMBER OR MEDICAID MANAGED CARE MEMBER

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

1.74 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

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

1.75 NETWORK

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

1.76 NETWORK PROVIDER

Network provider is any provider, group of providers or entity that has a provider agreement with the Contractor, or a subcontractor, and receives federal funding directly or indirectly to order, refer or render covered services as a result of this contract.

1.77 NON-PARTICIPATING PHYSICIAN

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

1.78 NON-PARTICIPATING PROVIDER

Non-participating provider is a provider (doctor, hospital, pharmacy, etc.) that does not sign a contract to participate in the Contractor’s provider network. If a beneficiary receives service from an out of network provider, the health plan may pay for the service at a reduced rate or may not pay at all.

1.79 OVERPAYMENT

Overpayment is a payment made to a Contractor or network provider to which the Contractor or provider is not entitled to under Title XIX of the Act.

1.80 PARTICIPATING PROVIDER

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

1.81 PARTY

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

1.82 PATIENT CENTERED MEDICAL HOME

A Patient-Centered Medical Home (PCMH) provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. A PCMH must: be participating in or have completed a formal transformation initiative (i.e., CTC-RI, PCMH-Kids or a payer-sponsored program) and/or practice has obtained NCQA Level 3 recognition, within 24 months of seeking PCMH status under the Rhode Island Office of the Health Insurance Commissioner (OHIC) Affordability Standards, demonstrate meaningful performance improvement over an annual two-year look back period, or within 12 months of seeking PCMH status under the RI OHIC Affordability Standards, have implemented the following specific cost-containment strategies (strategy development and implementation at the practice level rather than the practice site level is permissible): (a) develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future; (b) practice uses data to implement care management, focusing on high-risk patients and interventions that will impact ED and inpatient utilization; (c) implements strategies to improve access to and coordination with behavioral health services; (d) expands access to services both during and after office hours; (e) develops service referral protocols informed by cost and quality data provided by payers; and (f) develops/maintains an avoidable emergency department use reduction strategy. Within 24 months of seeking PCMH status under the Affordability Standards, Practices demonstrate meaningful performance improvement over an annual two-year look back period.

1.83 PEER NAVIGATOR

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

1.84 PHYSICIAN SERVICES

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

1.85 PLAN

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

1.86 PLAN OF CARE

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

1.87 PLAN PHYSICIAN OR PARTICIPATING PHYSICIAN

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

1.88 POST-STABILIZATION CARE SERVICES

Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113(c)ⁱⁱ.

1.89 POTENTIAL ENROLLEE

A Medicaid eligible RIte Care, Rhody Health Partners, or an ACA Adult Expansion population individual who has not yet been enrolled by the Contractor

1.90 PRE-AUTHORIZATION

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization,

prior approval or precertification.

1.91 PREMIUM

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

1.92 PREPAID BENEFIT PACKAGE

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

1.93 PREPAID INPATIENT HEALTH PLAN

Prepaid inpatient health plan means a plan which provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates, provides for the any inpatient hospital or institutional services, and does not have a comprehensive risk contract.

1.94 PRESCRIPTION DRUG COVERAGE

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

1.95 PRESCRIPTION DRUGS

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

1.96 PREVALENT

Prevalent means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

1.97 PRIMARY CARE

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, obstetrician/gynecologist, geriatric physician or other medical specialists, to the extent the

furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

1.98 PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physician (PCP) is a class of physicians that typically includes internists, family physicians, pediatricians, and obstetricians/gynecologists. As PCPs, these physicians may control access that managed care plan members have to other plan services such as diagnostic testing or visits to specialists.

1.99 PRIMARY CARE PROVIDER (PCP)

Primary Care Provider means the individual Plan Physician or team selected by or assigned to the member to provide and coordinate all of the member's health care needs and to initiate and monitor referrals for specialized services when required. Primary Care Providers will be Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, gynecology, internal medicine, geriatrics, or other medical specialists who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who are prepared to undertake the responsibilities of serving as a PCP as stipulated in the Contractor's primary care agreements. Primary Care Providers also will meet the credentialing criteria established by the Contractor and approved by EOHHS. NCQA certified Patient Centered Medical Homes will be included in the Contractor's network as a primary care provider. The Primary Care Provider may designate other participating plan clinicians who can provide or authorize a member's care.

1.100 PRIVATE DUTY NURSING

Private Duty Nursing means those skilled nursing services authorized by a physician when the physical or mental condition of the patient requires more skilled nursing than intermittent visiting nursing care and takes into account family strengths and other family obligations.

1.101 PROVIDER

Provider means an individual or entity including physicians, nurse practitioners, physician assistants and others that are engaged in the delivery of medical/behavioral health care services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

1.102 PROVIDER PREVENTABLE CONDITIONS

Provider-preventable condition means a condition that meets the definition of a "health care-

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

1.103 RATE CELL

Rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for purpose of determining the capitation rate.

1.104 RATING PERIOD

Rating period means a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification.

1.105 READILY ACCESSIBLE

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

1.106 REHABILITATION SERVICES

Rehabilitation services are health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

1.107 RELATED GROUPS

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

1.108 RHODY HEALTH PARTNERS

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

1.109 RHODY HEALTH PARTNERS ELIGIBLE

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

1.110 RISK CONTRACT

Risk contract means an agreement under which the Contractor assumes financial risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the agreement.

1.111 RISK CORRIDOR

Risk corridor means a risk sharing mechanism in which the State and the Contractor may share in profits and losses under the contract outside of the threshold amount.

1.112 RITE CARE

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

1.113 RITE CARE ELIGIBLES

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

1.114 RITE SHARE

Rite Share is the premium assistance program created and operated under Chapter 40-8.4-12 et seq. of the Rhode Island General Laws and the amended state plan under Title XIX (Medicaid) for the State of Rhode Island pursuant to which EOHHS will purchase employer-sponsored health insurance for Rite Care Eligible low-income working individuals and their families who

are eligible for employer-sponsored insurance but could not otherwise afford such insurance.

1.115 RITE SHARE MEMBER

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

1.116 SHORT-TERM CARE MANAGEMENT

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

1.117 SIBLING

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

1.118 SKILLED NURSING CARE AND SKILLED CARE SERVICES

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

1.119 SPECIALIST

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

1.120 SSI

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

1.121 STABILIZED

The attending emergency physician, or the medical provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

1.122 STATE

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

1.123 STOP LOSS

Stop-loss means the mechanism by which EOHHS will reimburse Contractor for the expenses of specific benefits exceeding limits referenced in this Agreement. Stop-loss provisions will apply on a calendar year basis for Contract Period #1 (ending June 30, 2018) and Contract Period #2 (beginning July 1, 2018) and for any subsequent Contract Periods, as described in ATTACHMENT N, Special Terms and Conditions, Sections 12 and 13 of this Contract.

1.124 SUBCONTRACTOR

Subcontractor means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor obligations under this contract with the State.

1.125 SUSPENSION

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

1.126 TELEHEALTH

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.

1.127 TOTAL COST OF CARE (TCOC)

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally it includes a historical baseline or benchmark cost of care specifically tied to an attributed population in an APM arrangement, (including, for example, an Accountable Entity's attributed population) projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to keep their attributed population well with the goal of improving

outcomes that result in earned shared savings to the Contractor and EOHHS. Shared savings distributions must be scaled in light of comprehensive and well-defined quality and outcomes metrics.

1.128 UNINSURED

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

1.129 URGENT CARE

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

1.130 URGENT MEDICAL CONDITION

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

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

1.131 WITHHOLD ARRANGEMENT

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

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

2.01 GENERAL

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

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

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

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

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

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

Pursuant to the development of accountable care delivery models for each period, the Contractor will meet or exceed the requirements set forth in Section 2.01.01 for the percent of their total

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

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

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

Throughout sections 2.01.01.01 and 2.01.01.02, there are provisions which are conditionally effective and are so indicated. The condition will be related to the Contractor's total RI Medicaid product beneficiaries and the opportunity for AEs to reach minimum attributed lives from this Contractor. As such, the Contractor will not be obligated to comply with the indicated provisions until total RI Medicaid membership is at or exceeds 10,000 beneficiaries. Upon reaching 10,000 beneficiaries, the Contractor will be required to subcontract with at least one EOHHS certified Accountable Entity which has at least 3,000 attributed lives. This requirement expands to subcontracts with two Accountable entities covering at least 10,000 lives when overall membership reaches 25,000. AE subcontract requirements revert to the provisions following once overall RI Medicaid membership reaches or exceeds 60,000 members.

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

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

Transformation Project and are incorporated as central requirements within this Agreement. The Contractor is required to meet targets for Alternative Payment Methodologies as set forth in Section 2.01.01.01, Alternative Payment Methodologies.

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

2.01.01.01 Alternative Payment Methodologies

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

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

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

For each contract period, the Contractor will meet or exceed the requirements set forth in Rhode Island Executive Office of Health and Human Services' "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" for the percent of their total payments made to providers using EOHHS approved alternative payment methods. APM contracts may not include the delegation of network contracting, provider payment, and/or claims processes, member services, or grievance and appeals functions without the express written consent of EOHHS. For any other function (e.g. care management) that is delegated, the Contractor must have an established process for assessing the capability of the subcontractor to

assume responsibility for the delegated function(s) and have an established policy and procedure for overseeing performance of such function(s). The Contractor must have a written plan for its monitoring and oversight of the performance of all contracts with providers using APMs. Such oversight will include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice. Upon request by EOHHS, the Contractor will submit an electronic copy of its written plan for monitoring and oversight of all APM subcontractors.

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

Such subcontracts will be in compliance with the EOHHS program requirements applicable to the time period. For subcontracts with entities certified as Accountable Entity Coordinated Care Pilots, contracts between the Contractor and the certified AE will be in compliance with "Rhode Island Executive Office of Health and Human Services" "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners, January 2016".

For contracts with entities certified as comprehensive Accountable Entities, subcontracts between the health plan and the certified AE will be in compliance with *Rhode Island Executive Office of Health and Human Services* "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners" for the applicable time period.

Hereinafter these documents are referred to as *RI EOHHS' Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*. The Contractor's compliance with these requirements pertains to the applicable type of certified AE and the applicable time period (e.g., the Contract Period).

Total cost of care (TCOC) calculation methodologies serving as the basis for shared savings and/or risk arrangements with AEs must adhere to EOHHS APM Requirements. Compliance of TCOC methodology with EOHHS TCOC requirements must be determined by the EOHHS in advance of execution of such contract. EOHHS will review the Contractor's proposed TCOC methodology to assure compliance with requirements before granting approval. Transparency in such arrangements is required in conformance with 42 CFR Section 438.6ⁱⁱⁱ. Based on 42 CFR 436.6(g), any Contractor/AE risk arrangements must stipulate that the EOHHS and the DHHS may inspect and audit any financial records of the Contractor or its subcontractors. Any physician incentive plans must comply with the requirements in 42 CFR 438.6(h)^{iv} and 42 CFR 422.210.

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

All provisions in this Agreement pertaining to EOHHS certified AEs apply to the AE coordinated Care Pilot AEs and Comprehensive AEs unless expressly stated otherwise.

2.01.01.01.01 Capitation Withhold and Adjusting Payments

Effective July 1, 2018, and continuing through Contract Period 5, EOHHS will withhold 0.5% of monthly capitation amounts. EOHHS will consider the withhold, for the prorated period of July 1, 2018 through December 31, 2018, as earned due to the Contractor's efforts in advancing the development of APMs. The withheld amounts will be repaid as quarterly adjusting payments subject to the Contractor's demonstration that it has achieved the threshold values in APM payments for the reporting period as set forth in Section 2.01.01.01.02 (Alternative Payment Methodology for Each Contract Period). Such demonstration will be on the basis of quarterly submissions of the "Alternative Payment Methodology Reporting Template for Managed Care Organizations" (included as ATTACHMENT D to *"Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners."*) and EOHHS review of the submitted report. If the Contractor does not achieve the threshold value within the prescribed period, EOHHS will consider the amount forfeited and retained accordingly. Quarterly submissions and adjusting payments will be based on cumulative performance for the Contract Period.

The Contractor submissions to EOHHS of the "Alternative Payment Methodology Reporting Template for Managed Care Organizations" will not be later than forty-five (45) days after the end of each quarter. EOHHS will review the report within thirty (30) days of receipt of the report. Based on review by EOHHS of the completeness and accuracy of the report adjusting payments to the Contractor within forty-five (45) days of receipt of the report.

2.01.01.02 Accountable Entities

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

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

- Qualifying APM covered benefit expenditures for inclusion in TCOC arrangements
- Attribution Method
- Requirements for Total Cost of Care (TCOC) arrangements
- Required quality score Factor
- Provisions regarding downside risk

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

2.02 LICENSURE AND ACCREDITATION

The Contractor certifies that it is licensed in Rhode Island as an HMO under the provisions of Chapter 27-41, "the HMO Act" or that it will become licensed as a Health Maintenance Organization (HMO) or Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Business Regulation prior to signing an Agreement with EOHHS. If the Contractor is not a licensed HMO in Rhode Island, the Contractor certifies that it is either a nonprofit hospital service corporation that is licensed by the Rhode Island Department of Business Regulation ("DBR") under Chapter 27-19 of the Rhode Island General Laws, a nonprofit medical service corporation that is licensed by DBR under Chapter 27-20 of the Rhode Island General Laws, or another health insurance entity licensed by DBR, and that it meets the following requirements:

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

- Is accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid Managed Care organization or otherwise for a newly entering plan:
 - The Contractor must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid Managed Care organization in another State and;
 - The Contractor must submit a specific timeline outlining the Contractor's plan to achieve full accreditation within twelve months of the execution of the contract and;
 - Failure to obtain accreditation by the date specified will result in the suspension of enrollment.
- Is certified by a nationally known health utilization management organization.
- Ensuring access to high quality and cost-effective services to all Rhode Islanders is paramount. , It is suggested the Contractor obtain NCQA distinction in Multicultural Health Care.

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

Contractor agrees to notify EOHHS, within thirty (30) days, of any complaint, investigation,

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

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

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

2.03 HEALTH PLAN ADMINISTRATION

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

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

2.03.01 Executive Management

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

2.03.02 Other Administrative Components

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

- Medical Director's Office
- Accounting and Budgeting Function

- Member Services Function
- Provider Services Function
- Medical Management Function, including quality assurance, prior authorization, concurrent medical review/discharge planning, and retrospective medical review
- Grievance and Appeals Function
- Claims Processing Function
- Management Information System
- Program Integrity and Compliance

2.03.03 RI Works Participants

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

2.03.04 Contract Readiness Review Requirements

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

2.03.04.01 EOHHS Readiness Review Responsibilities

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

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

- Network provider composition and access;

- Staffing, including key personnel and functions directly impacting Enrollees;
- Capabilities of First Tier, Downstream and Related Entities;
- Content of Health Care Professional Contracts, including any provider performance incentives;
- Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities);
- Comprehensiveness of quality management/quality improvement and Utilization Management strategies;
- Internal Grievance and Appeal policies and procedures;
- Fraud and abuse and program integrity policies and procedures;
- Financial solvency; and
- Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data.

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

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

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

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

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

2.04 ELIGIBILITY AND PROGRAM ENROLLMENT

2.04.01 Rite Care Eligible Groups

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

2.04.01.01 Five Base Rite Care Eligible Groups

The Rite Care population consists of five different eligible groups, or aid categories (the defined groups represent a consolidation of various aid categories). Qualification for the program is based on a combination of factors; including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category. The scope of benefits, program cost-sharing options/requirements and enrollment procedures vary by aid category and are described herein.

2.04.01.01.01 Eligibility of Families

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

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

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

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

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

benefits, as described below, through delivery and two months post-partum.

2.04.01.01.04 Eligibility of Extended Family Planning Group

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

2.04.01.01.05 Eligibility of Children with Special Health Care Needs

This category includes: (1) blind/disabled individuals up to age 21 eligible for Medicaid based on SSI; (2) children eligible under Section 1902(e)(3) of the Social Security Act (“Katie Beckett” children) up to age 19; (3) individuals up to age 21 receiving subsidized adoption assistance; (4) children in substitute care (“foster care”). Enrollment in Rite Care for these children will be based on EOHHS determination of managed care eligibility; and (5) adults age 21-26 who were previously active with the Department of Youth and Family Services (DCYF) and do not have other comprehensive coverage and (6) youths who opt to remain in the care of DCYF up to age 21 if they entered foster care on or after their 16th birthday and did not achieve permanency (i.e. adopted, reunified, etc.) and were set to age out of foster care. Children and youth eligible on the basis of their participation in a DCYF foster care, kinship or guardian program whether in a home-based, residential or institutional setting, as applicable.

2.04.01.02 Three Related Groups

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

2.04.01.02.01 Eligibility of Conversion Group

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

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

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

2.04.01.02.03 Other Medicaid Clients in Rite Care Households

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

2.04.02 Rite Care Health Plan Lock-In

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

2.04.03 Rite Care Guaranteed Eligibility

There are no eligibility guarantees for Rite Care members.

2.04.04 Rhody Health Partners Eligible Groups

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

2.04.05 Rhody Health Partners Eligible Determination

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

2.04.06 Rhody Health Partners Guaranteed Eligibility

There are no eligibility guarantees for Rhody Health Partners members.

2.04.07 Rhody Health Partners Health Plan Lock-In

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

2.04.08 Affordable Care Act Eligible Population

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

2.04.08.01 Eligibility Determination

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

2.04.08.02 Guaranteed Eligibility

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

2.04.09 New Eligibility Groups

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

2.04.10 Non-Biased Enrollment Counseling

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

- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about managed care in general, including: the option to enroll in a Health Plan; the way services typically are accessed under managed care; the role of the Primary Care Provider (PCP); and the responsibilities of the Health Plan member.
- Educating the Potential Enrollee and his or her family, guardian or adult caregiver about benefits available through the Contractor's Health Plan, both in-plan and out-of-plan.
- Informing the Potential Enrollee and his or her family, guardian or adult caregiver of available Health Plans and outlining criteria that might be important when making a choice, e.g., presence or absence of an existing PCP or other providers in a Health Plan's network.

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

2.04.11 Voluntary Selection of Health Plan by Members

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

2.04.12 Automatic Assignment to Health Plans

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

2.04.13 Automatic Re-Assignment Following Resumption of Eligibility

Members who are disenrolled from a Health Plan, due to loss of eligibility and who regain eligibility within sixty (60) calendar days of disenrollment, may select a Health Plan of their choice. Member who do not make a Health Plan selection will be automatically re-enrolled, or assigned, into their previous Health Plan upon reinstatement of their Medicaid eligibility. If more than sixty (60) calendar days have elapsed and the Medicaid member does not make a Health

Plan selection at the time eligibility was reinstated, the member will be auto-assigned to a Health Plan based on EOHHS' algorithm referenced in Section 2.04.12

2.05 MEMBER ENROLLMENT AND DISENROLLMENT

2.05.01 Health Plan Marketing

The Contractor is required to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing for open enrollment periods that will be distributed to members or potential members (referred to as member and marketing materials) before they are distributed. Plan materials developed or distributed by subcontractors or providers also require review and approval before being distributed. Member materials include, but are not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS. The Contractor is required to use RI EOHHS Model Member Handbook and Appeals/Grievances Notification Model Documents. Contractors are required to add MCO specific language to Model Documents. EOHHS requires the review and prior approval of all materials related to or containing information that is intended to be used for education, outreach or marketing purposes for MCO enrollees or prospective enrollees. Contractors are required to comply with the information requirements and marketing guidelines under 42 C.F.R. Section 438.10 and 438.104; 2019 EOHHS Marketing Guidelines For Marketing and Member Communications and Marketing requirements set forth in the CMS Medicaid and CHIP Final Rule. The Contractor agrees to submit marketing strategy and plans if requested.

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

The Contractor agrees to develop member materials that comply with 42 CFR 438.104ⁱ and *Guidelines for Marketing and Member Communication Materials for Rhode Island's Medicaid Managed Care Programs*. Written material must use easily understood language and format and satisfy all the requirements provided for in 42 CFR 438.10. In accordance with 42 CFR 438.104(b)(2)(i), the Contractors may not communicate, either in writing or orally, any statements that enrollees must enroll in the Health Plan to obtain benefits or to not lose benefits. The Contractor may not communicate, either in writing or orally to enrollees that CMS, the Federal or State government or similar entity endorse the Contractor. All written material must be written at no higher than a sixth-grade level. Written material must be available in alternative formats (e.g. audio and large print) and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State which include: (1) Spanish, (2) Portuguese, (3) Chinese, (4) French Creole

(Haitian Creole), (5) Mon-Khmer/Cambodian, (6) French, (7) Italian, (8) Laotian, (9) Arabic, (10) Russian, (11) Vietnamese, (12) Kru (Bassa), (13) Ibo, (14) Yoruba*, and (15) Polish. Taglines must be written in large print which is defined as 18-point font and explains the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). The Contractor must make auxiliary aids such as TTY/TDY and American Sign Language, available to potential members and members with disabilities free of charge as required by 42 CFR 438.10(d)(4). All potential enrollees and members must be informed that information is available in alternative formats and how to access those formats. However, such alternative media will not be a substitute for the requirement that the Contractor provide all members with a written member handbook except for those members with special needs that warrant an alternative format. Materials will be available in alternate languages for those members with limited or no English proficiency. The State will determine whether the Contractor's marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104¹.

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

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

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

2.05.02 Health Plan Enrollment Procedures

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

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

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

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

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

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

2.05.02.01 Enrollment of Newborns Up to 250% of FPL

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

The Contractor will supply EOHHS with all necessary files in order to enroll newborns of the adult expansion population members.

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

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

2.05.02.02 Enrollment in Extended Family Planning

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

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

The Contractor agrees to make coverage available to uninsured children under eighteen years of age with income above 250 percent of the Federal poverty level, at a monthly premium rate (payable by the family) not to exceed the full community rated non-group premium for the defined benefit package, as described later in this chapter. The Contractor may not require evidence of insurability; however, it may restrict enrollment to:

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

2.05.02.04 Enrollment under the Conversion Option (Related Group)

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

2.05.03 Change in Status

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

2.05.04 Enrollment and Disenrollment Updates

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

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

2.05.05 Services for New Members

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

2.05.06 New Member Orientation

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

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

2.05.07 Assignment of Primary Care Providers (PCPs)

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

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.
- If a Medicaid-only member does not select a PCP during enrollment, the Contractor will make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. The Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. The Contractor will auto assign members to a NCQA recognized Patient Centered Medical Home, where possible.
- In addition to the above, EOHHS recognizes the importance of members being enrolled in a certified AE and a Patient Centered Medical Home (PCMH). EOHHS expects that, as applicable to the eligible populations, the Contractor will prioritize auto-assignment (a) first, to PCPs in a PCMH practice that is also a participating provider in a certified and contracted AE; second, to PCPs in a PCMH practice that are not in a contracted AE; third to non-PCMH PCP participating in a contracted AE; and fourth to PCPs in a non-PCMH and non- AE participating practice.

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

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

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

2.05.08 Changing PCPs

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

2.05.09 Identification Cards

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

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

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

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

2.05.10 Member Handbook and Initial New Member Materials

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

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

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

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

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

2.05.10.01 Required Information

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

- Information on how to obtain a member handbook and Provider Directory

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

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

- Information on member services.
- Information on how to choose a PCP. Each member may choose his or her PCP to the extent possible and appropriate.
- Information on what to do when family size changes.
- Information on obtaining transportation
- Information on Interpreter and Translation Services
- Any restrictions on the member's freedom of choice among network providers.
- Information that enrollment Medicaid Managed Care does not restrict the choice of the provider from whom the member may receive family planning services and supplies.
- Information on member's right to change PCP.
- Information on amount, duration, and scope of Covered Services, including how to access Covered Services including behavioral health and long-term services and supports. This information must include sufficient detail to ensure that the member understands the benefits to which they are entitled.
- Procedures for obtaining benefits, including authorization requirements.
- Right to a second opinion.
- Members may obtain benefits, including family planning services, from out-of-network providers.

- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition, emergency services, and Post-Stabilization Care Services, with references to the definitions in 42 CFR 438.114(a)^{viii}.
 - The fact that prior authorization is not required for Emergency Services.
 - The process and procedures for obtaining Emergency Services, including use of the 911-telephone system or its local equivalent.
 - The locations of any Emergency Services and Post-Stabilization Care Services covered under the Agreement.
 - The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.
- Information on the post-stabilization care services rules set forth in 42 CFR 422.113^{ix}.
- Policy on referrals for specialty care and other benefits not furnished by the member's Primary Care Provider.
- Information on Advance Directives as set forth in 42 CFR 438.6(i)(2) iv and 42 CFR 422.128^x. The Contractor agrees to reflect any changes in State law with regards to Advance directives in its written material within ninety (90) days of the effective date of the change as set forth in 42 CFR 438.6(i)(4).
- Information on out-of-plan or out-of-network benefits
- Information on member's rights and responsibilities, including, in conformance with State and Federal law, the rights of mothers and newborns with respect to the duration of hospital stays.
- Information on member's rights and protections, as specified in 42 CFR 438.100^{xi}.
- Information on formal grievance, appeal and fair hearing procedures, and the information specified in 42 CFR 438.10(g)(1)^{xii}
- Information that a member may request disenrollment at any time from the Health Plan
- Information on cost-sharing responsibilities (if applicable; may be included as an insert)

- Information on non-covered services. How and where to access any benefits that are available under the State plan but are not covered under this Agreement, including any cost sharing, and how transportation is provided.
- Information on member and provider fraud, waste and abuse
 - Provide examples of possible Medicaid fraud and abuse which might be undertaken by providers, vendors and enrollees
 - Inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free number established by the Contractor for reporting possible fraud and abuse
 - Instruct enrollees about how to contact EOHHS's Fraud Unit
- Information on grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400^{xiii} through 42 CFR 438.424^{xiv}, in a State-developed or State approved description that must include the following:
 - The member's right to a State Fair Hearing, how to obtain a hearing, and the right to representation at a hearing
 - The member's right to file grievances and appeals and their requirements and timeframes for filing
 - The availability of assistance in the filing process
 - The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone
 - The member's right to request continuation of Covered Benefits during an appeal or State Fair Hearing within the timeframes specified for filing; and the member may be liable for the cost of any continued benefits while the appeal is pending, if the final decision is adverse to the enrollee (as defined in 42 CFR 438.420^{xv}).
 - Information on other resources to assist members
- Additional information that is available upon reasonable request, including the following:
 - Information on the structure and operation of the Contractor
 - Reports of transactions between the Contractor and parties of interest that are provided to the State, or other agencies. 1903(m)(4)(B).
 - Information on any physician incentive plans as set forth in 42 CFR 438.6ⁱⁱⁱ

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

- How does the Health Plan review and approve Covered Services?
- What if I refuse referral to a participating provider?
- Does the Health Plan require that I get a second opinion for any services?
- How does the Health Plan make sure that my personal health information is protected and kept confidential?
- How am I protected from discrimination?
- If I refuse treatment, will it affect my future treatment?
- How does the Health Plan pay providers?
- If I am covered by two or more Health Plans, what do I do?

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

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

The Contractor must provide members, in adherence with 42 CFR 438.10(f)(4) with written notice of any significant changes in enrollee rights or information at least thirty (30) days before the intended effective date of the change.

2.05.10.02 Provider Directory/Network Listing

The Contractor agrees to develop a provider network listing and make it available to all new and existing members at all times. An electronic copy of the provider network listing is to be included on the Contractor's member website and available for viewing and downloading. Additionally, members may request an alternate version (paper, audio or specific language) by contacting the Contractor's Member Services Department. Members receiving a hard copy of the network listing will be advised that the Contractor network may have changed since the directory was printed, and how to access current information regarding the Contractor's participating providers. The Contractor will update information included in their paper provider directory at least monthly and their electronic provider directory no later than thirty (30) calendar days after the Contractor received updated provider information.

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

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

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

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

2.05.10.03 State Approval

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

2.05.10.04 Languages Other Than English

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

2.05.11 Transitioning Members between Plans

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

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

- Access to services consistent with the access the member previously had, and the member is permitted to retain their current provider for a period of one-hundred and eighty (180) days if that provider is not in the Contractor's network;
- Referrals to appropriate providers that are in the network;

- Fully and timely compliance with requests for historical utilization data from the new MCO in compliance with Federal and State law; and
- Any other necessary procedures as specified by EOHHS to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

2.05.12 Member Disenrollment

2.05.12.01 General Authority

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

2.05.12.02 Reasons for Disenrollment

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

- Loss of Medicaid eligibility or medically needy
- Loss of program eligibility
- Transfer to another Health Plan
- Death
- Relocation out-of-State
- Adjudicative actions
- Change of eligibility status
- Placement in a nursing facility for more than thirty (30) consecutive days, for Rhody Health Partners and Expansion members only
- Placement in Eleanor Slater, Tavares or an out-of- state hospital
- Eligibility determination error

- Just cause (as determined by EOHHS on an individual basis)
- The enrollees service needs (e.g. cesarean section and a tubal ligation) are not available within the network and that the enrollee's primary care provider or another provider determines that not receiving the services will subject the enrollee to unnecessary risk.
- Other reasons for disenrollment include but are not limited to: poor quality of care, lack of access to providers experienced in dealing with the enrollee's health needs.

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

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

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

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

2.05.12.03 Disenrollment Effective Dates

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

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

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

Rlte Care members, who obtain eligibility through criteria described in Section 2.04.01.01.3, Eligibility of Pregnant Women Under 250 Percent of the FPL ("SOBRA-

Extension Group"), who are required to pay the premium-share and who fail to make premium payments for two (2) consecutive months, will be dropped from the program.

2.05.12.05 Disenrollment of Related Group

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

2.05.12.06 Retrospective Enrollment and Retrospective Disenrollment

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

2.05.12.07 Exemptions for Indians Served by an Indian Healthcare Provider

Indians Served by an Indian Health Care Provider. The Contractor will exempt Indians from payment of enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly

by an Indian health care provider, I/T/U or through CHS. The Contractor must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

2.06 IN-PLAN SERVICES

2.06.01 Description of Comprehensive Benefit Package

2.06.01.01 General

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

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

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

The defining core values driving service delivery are:

- Population Health

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

The guiding principles for service delivery are:

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

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

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

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

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

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

Management Programs. The Contractor will provide comprehensive treatment for gender dysphoria for all into the list of services included in the comprehensive benefit package.

2.06.01.02 Medical Services

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

2.06.01.03 Behavioral Health Services

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

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

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

2.06.01.04 Pharmacy Services

The Contractor agrees to comply with the requirements regarding covered pharmacy and over-

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

2.06.01.05 Preventive Services

The Contractor may provide certain LTSS services in a limited fashion to members who do not currently meet the eligibility criteria for LTSS, to prevent admission, re-admission or reduce lengths of stay in an institution. These Preventive Services are outlined in ATTACHMENT A.

2.06.01.06 Interpreter/Translation Services

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

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

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

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

2.06.01.07 Telehealth

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

2.06.01.08 EPSDT

The Contractor agrees 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 as included in ATTACHMENT E or modified by EOHHS during the period of this Agreement.

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

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

Screening

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

- A comprehensive health and developmental history, including health education, nutrition assessment, immunization history, and developmental assessment
- Immunizations according to the Rhode Island EPSDT Periodicity Schedule
- An unclothed physical examination
- Laboratory tests including lead, TB, and newborn screenings as medically indicated
- Vision testing
- Hearing testing
- Dental screening oral examination by PCP as part of a comprehensive examination required before age one (1)
- All other medically indicated screening services

Diagnosis and Treatment

If a suspected problem is detected by a screening examination as described above, the member

will be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

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

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

Tracking

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

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

Follow-up and Outreach

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

- Written notification of upcoming or missed key points of contact within a set time period, taking into consideration language and literacy capabilities of members.
- Telephone protocols to remind members of upcoming visits and follow-up on missed appointments within a set time period.
- Protocols for conducting outreach with non-compliant members, including home visits, as appropriate, and addressing access barriers such as arranging transportation, interpreters, connections with multi-lingual/multi-cultural service providers, etc.

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

2.06.01.09 Enhanced Services

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

General Tracking, Follow-up and Outreach

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

- Educate members about how to access services including the role of the PCP, prior authorization requirements, and after-hours access requirements.
- Educate members about preventive visit and screening recommendations, including an initial visit to the PCP for all new enrollees.
- Establish tracking systems to measure member compliance with preventive service recommendations and with referral recommendations that result from preventive visits.
- Remind members about upcoming preventive visits/screens and conduct vigorous follow-up and outreach with members who miss visits, using mail, telephone, and home outreach methods as appropriate.
- Remind members about upcoming appointments and conduct vigorous follow-up and outreach with members who miss visits, using mail, telephone, and home outreach methods as appropriate.
- Identify and resolve member barriers to preventive care (such as language or transportation).

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

Prenatal Tracking, Follow-up and Outreach

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

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

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

Tobacco Cessation

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

Nutrition Services

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

Transportation

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

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

2.06.01.10 In Lieu of Services

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

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

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

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

- Psychiatric or Substance use disorder treatment provided in an Institution of Mental Disease (IMD) for members between the ages of 21-64 for a period of no more than fifteen (15) days. The Contractor will comply with all court-ordered length of stays.

2.06.01.11 Coverage of Complementary Alternative Medicine Services (CAM)

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

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

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

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

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

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

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

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

- Data on CAM service providers.
- Data on members receiving CAM services.
- Pain reduction/pain management success rates.
- Lessons learned and recommendations for improvement/modifications.

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

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

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

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

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

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

2.06.02 Enrollee/Provider Communication

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

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

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

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

2.06.03 Second Opinion

A member is entitled to a second opinion from a qualified health professional within the network or request that the Contractor arrange for a second opinion by a non-participating provider outside the network, at no cost to the member.

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

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

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

2.06.05 Care Management and Care Coordination

2.06.05.01 Coordination of Care

The Contractor will ensure coordination of care of all covered benefits under this Agreement including those provided for children, adolescents and adults for RItE Care, Rhody Health Partners and the Affordable Care Act Adult Expansion Populations. Coordination of care

includes identification and follow-up of members with significant health and social needs that are at high risk of poor health outcomes, ensuring coordination of services and appropriate referral and follow-up. In particular, the Contractor will ensure coordination between medical services and behavioral health services required by the members.

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

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

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

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

2.06.05.02 Children with Special Health Care Needs

The coordination of care is of the utmost importance for Children with Special Health Care Needs. The Contractor will treat Children with Special Health Care Needs as a high-risk population.

The Contractor is required to be in compliance with all DCYF policies regarding the care and treatment of youth in substitute care. The Contractor is required to meet with DCYF and EOHHS

at a time interval specified by EOHHS and is required to provide timely ad-hoc reports when requested.

2.06.05.03 Continuity of Care for Former Qualified Health Plan Members

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

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

2.06.05.04 Care Management Program

The Contractor is responsible for ensuring by the contract start date that an EOHHS approved care management strategy and plan is in place, which addresses the preventive and chronic healthcare needs of its members, inclusive of behavioral health social services and supports and other social determinants that impact member health outcomes. The care management strategy and plan for members with significant health and social needs that are at high risk of poor health outcomes, including, but not limited to, adults with complex health needs, Children with Special Health Care Needs, other children with potentially care management service's needs, individuals receiving home and community based services or children with high need, HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional facilities. The care management plan will describe the care management program including but not limited to the policies, procedures, practices and criteria for conducting the Health Risk Assessment and conducting providing care coordination and Intensive Care Management Services that comply

with the requirements contained in ATTACHMENT G. The Care Management strategy and plan is subject to the approval of EOHHS. The Contractor will submit the Care Management strategy and plan to EOHHS thirty (30) days prior to the contract commencement date.

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

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

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

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

The Contractor will maintain records to identify care coordination and Intensive Care Management activities. For all members receiving intensive care management, records will include the resulting Intensive Care Management Plan or documentation of why such a plan is not needed.

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

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

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

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

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

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

2.06.05.06 Recovery Navigation Program (RNP)

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

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

2.07.01 General

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

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

2.07.02 Non-Emergency Transportation

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

2.07.03 Special Education

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

2.07.04 Department of Behavioral Health, Developmental Disabilities and Hospitals

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

2.07.05 Rhode Island Department of Human Services

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

2.07.06 Rhode Island Department of Health

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

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

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

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

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

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

2.07.06.02 Adolescent Self-Sufficiency Collaborative

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

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

2.07.07 Care Transformation Collaborative of Rhode Island

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

2.07.08 Level IV Alcohol and Drug Detoxification Program

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

2.07.09 CurrentCare

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

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

2.07.10 Dental Services

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

2.07.11 All Payer Claims Database

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

2.08 PROVIDER NETWORKS

2.08.01 Network Composition

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

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

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

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

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

member is held harmless. The Contractor will report out of network utilization by provider type as part of the monthly access reporting to EOHHS.

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

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

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

Nothing in this section may be construed to:

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

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

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

- Not execute provider agreements with providers who have been excluded from participation in the Medicaid/CHIP and/or Medicare programs pursuant to Sections §1128 or §1156 of the Social Security Act or who otherwise is not in good standing with RI Medicaid.

- Have written policies and procedures for the selection and retention of providers. These policies and procedures will not discriminate against providers who service high risk populations or specialize in conditions that require costly treatment.
- The Contractor will have written policies and procedures for the selection and retention of providers that comply with 42 CFR 438.214^{xxi} and with the State's policy for credentialing and re-credentialing.
- Not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification as defined by State law, solely on the basis of that license or certification.
- Have policies and procedures to assure providers and office staff comply with the cultural and disability competency requirements
- Give affected providers written notice if it declines to include individual or groups of providers within its network,
- Each individual or group provider in the network must has a unique identifier assigned to them.

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

2.08.02 Contracting with EOHHS Certified Accountable Entities

2.08.02.01 EOHHS Certification of AEs

Fundamental to EOHHS' HSTP program is the certification of Accountable Entities. Certified AEs are eligible to enter into EOHHS approved APM contractual arrangements with EOHHS contracted managed care organizations. MCOs are contractually required to enter into such arrangements with certified AEs. Arrangements with certified AEs must compliant with APM requirements and provisions for incentive-based payments through the HSTP as set forth in this Section 2.08.02. AEs that are certified by EOHHS pursuant to EOHHS' certification process that was initiated on November 15, 2017 are further eligible to qualify for incentive-based payments through the HSTP.

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

2.08.02.02 Requirements for Contracting with EOHHS Certified AEs

Requirements for contracting with EOHHS Certified AEs are articulated in *RI EOHHS, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*.

Beginning with Contract Period 2 effective July 1, 2018, and continuing through Contract Period 5, in the event that the Contractor does not meet the requirements for subcontracting with AEs, at its sole discretion EOHHS may reduce capitation payments by up to 0.5% for each month that the Contractor is non-compliant with these requirements and EOHHS will pursue alternative pathways to provide HSTP related incentive fund opportunities to EOHHS certified AEs.

The Contractor must have a written plan for its monitoring and oversight of the performance of AE subcontractors. Such oversight will include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice. Upon request by EOHHS, the Contractor will submit an electronic copy of its Contractor's written plan for monitoring and oversight of its AE subcontractors

2.08.02.03 Operational Requirements for Management of APM Subcontracts with Accountable Entities

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

- *Implementation of shared management structure* such as a Joint Operating Committee that will meet regularly and not less than bi-monthly to ensure ongoing communication, support of collaborative activities, problem-solving, and ongoing review of progress in performance areas.
- *Provision of Monthly Attribution Rosters.* On a monthly basis, the Contractor will provide contracted AEs 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*". Attribution lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, and the results of quarterly updates to PCP assignment.
- *On a monthly basis, and upon AE request, provide and review timely, member specific utilization and cost data* to AEs to better enable AEs to examine and understand patterns of utilization by attributed members and develop plans of action. Such data may additionally identify high risk, high utilizer members, provider outlier analysis of high/low performing providers within an AE panel, and other data reports that are mutually agreed upon to be useful in managing the program. To meet this need, the Contractor is required to share a minimum data set with the contracted AE

for its attributed members at both a beneficiary-identifiable level as well as aggregate data. Such minimum data set is as set forth in ATTACHMENT U. The AE must certify that they are requesting this data as a HIPAA covered entity or as a business associate of a HIPAA-covered entity and that the requested data reflects the minimum data necessary for the AE to effectively conduct its health care operations as an AE. This includes activities to:

- Evaluate the performance of AE participants, and AE providers/suppliers,
- Conduct quality assessment and improvement activities
- Conduct population-based activities to improve the health of its assigned beneficiary population.

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

Oversight and Monitoring of Member Access to Care

The Contractor will:

- Ensure that AE Attributed Members are not limited to obtaining services only from AE affiliated Providers
- Ensure Participating AE providers are permitted to make referrals to any provider, as appropriate, regardless of the provider's affiliation with the AE
- Prohibit additional requirements for referrals to providers who are not Affiliated Providers;
- Maintain Attributed Members' access to or freedom of choice of providers;
- Maintain open access to Medically Necessary services; and
- Ensure that AE Attributed Members may obtain emergency services from any provider, regardless of its affiliation with the AE.
 - Ensure that AEs implement a contract compliance program to include at least the following:
 - Designated compliance official who is not legal counsel
 - Mechanism for identifying, and addressing compliance problem

Oversight and Monitoring of Quality of Care.

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

Financial Reporting and Settlement with AEs.

Subcontracts with AEs will include TCOC shared savings arrangements and may include shared risk arrangements in compliance with *“RI EOHHS’ Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*. Contracts with AEs will include provisions regarding transparency in the basis for setting TCOC targets, tracking TCOC performance, and provisions for periodic reporting and financial settlements.

Monitoring and reporting to EOHHS

The Contractor will:

- Monitor and report to EOHHS key operational, quality and access metrics specific to appeals, grievances, informal complaints, access to care, and others inclusive of reporting requirements set forth in ATTACHMENT N, SPECIAL TERMS & CONDITIONS.
- Monitor and report to EOHHS on AE Performance, trends and emerging issues within and among AEs on a monthly basis using a standardized reporting form. Such reporting will include material changes in the structure of the AE and any issues within the AEs that are impacting the AE’s ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary
- Annually, MCO must report an AE specific quality report for the AE attributed lives population for all pay-for-performance quality measures included in the Comprehensive AE Common Measure Slate as set forth in *“RI EOHHS’ Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*.
- Submit to EOHHS outcome metrics reporting for the program year in accordance with EOHHS requirements as set forth in *“RI EOHHS’ Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*.

2.08.02.04 HSTP and the Medicaid Infrastructure Incentive Program

As part of CFR 42 CFR 438.6, the State has the authority to implement incentive payments to

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

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

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

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

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

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

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

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

Structure of the Medicaid Infrastructure Incentive Program

Total funding available for the Medicaid Infrastructure Incentive Program (MIIP) will be established by EOHHS and set forth in the *EOHHS Medicaid Infrastructure Incentive Program*:

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

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

2.08.02.05 Development, Implementation, and Oversight of AEIP Program

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

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

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

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

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

The Contractor requirements are established as set forth below.

- **Execution of TCOC compliant contract**

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

- **Provide Guidance to the AEs to Submit HSTP AEIP Proposals.**

The Contractor will provide guidance to AEs to support development of approvable proposals. This guidance will include:

- A workplan that clearly addresses EOHHS priority areas and includes the type of activities targeted for funds has been developed for each core project.
- A description of clear milestones and timelines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.
- Core projects that include a clear statement of understanding of the intent of incentive dollars, including a clear description of the objective of the project and how achieving the objective will promote health system transformation.
- A gap analysis and explanation of how the project addresses identified gaps
- Clear interim and final project milestones and projected impacts, including criteria for recognizing achievement of milestones and quantifying impacts.
- Incentive funding is reasonable for the project identified, with funds clearly dedicated to the project, the level and apportionment of the incentive funding request is commensurate with the value and level of effort required.

- **Review Current Certification Status with AE,** including any certification conditions and gaps identified in the EOHHS certification process.

The EOHHS certification process will review the AE's technical proposal, organizational readiness, and proposed plans of action in each of the eight domains of certification. This will provide a profile of strengths and gaps to help guide AE proposal development and decisions on AEIP project plans and incentives.

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

To develop the most informed AEIP and effectively manage the health needs of an attributed population the AE needs a comprehensive view of the utilization patterns, characteristics, and service gaps of the population it is to manage.

Within thirty days of execution of an APM agreement with the AE, the Contractor will provide a population specific analysis of the AE's attributed population. This

assessment should provide a basis for risk segmentation of the population served by the AE that will help guide project plans. For example, data analyses may identify patterns of gaps in coordinated care for population subgroups such as adults with co-occurring medical and behavioral health needs and/or may identify avoidable inpatient or emergency department utilization in specific geographic areas. AE project plans should then focus on tangible projects within the certification Domain areas, such as IT capability, to identify and track needs or strengthen targeted care management or patient engagement processes. This provides for the linkage between recognized areas of need/opportunity and developmental tasks.

- **Establish and Convene Contractor Review Committee for Evaluation of AE Proposals and Recommendations for Action**

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

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

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

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

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

The Contractor will execute subcontracts with AEs for AEIP incentive program funds

to support AEs in developing and enhancing the capacity and tools required for effective system transformation and for achieving quality and performance outcomes. Subcontracts will specify performance requirements and associated milestones to be achieved for AEs to earn incentive payments.

Allowable incentive programs in subcontracts will align with EOHHS program priorities and identified AE-specific program needs and gaps. Allowable areas for incentives linked with certification domains, and performance areas and milestones are delineated in the *EOHHS Medicaid Infrastructure Incentive Program: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities*.

The AEIP will be established via a contract or contract amendment between the Contractor and the AE. EOHHS reserves the right to review and approve the terms of incentive contracts with AEs. Incentive contracts will specify performance requirements and milestones to be achieved for AEs to earn incentive payments. 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”.

- **Submit to EOHHS a Schedule of Projected Milestones and Payments for each AEIP**
- **Assess AE Performance to Determine Whether Incentive Payments Have Been Earned**
 - AE incentive payments will be conditional on demonstrated performance. Contract Review Committee will review and evaluate AE progress in achieving AEIP performance targets and determine whether AE performance warrants incentive payments.
 - EOHHS reserves the right to have a designee that participates on the Contractor evaluation committee to ensure the State’s engagement in the process of performance evaluation.
 - The Contractor must certify that an AE has met its approved metrics as a condition for its release of associated AEIP funds to the AE.
- **Make payments to the AE’s on a timely basis**

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

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

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

To be most effective as incentives it is important that incentive payments be meaningful and

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

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

	Payment Schedule	
	EOHHS to MCO	MCO to AE
Developmental Milestones: Fixed Percentage Allocations Based on Specific Achievements	EOHHS shall pay MCO for fixed milestones achieved within 30 days of receipt of the quarterly AEIP Milestones Report documenting achievement of the milestone. The first AEIP Milestones Report shall be submitted to EOHHS for the quarter ending September 30 th . Report must be submitted within 30 days of the completion of the quarter.	Not later than 30 days after receipt of payment from EOHHS, MCO shall make payment for fixed milestones achieved to the AE.
Outcome Metrics	EOHHS shall pay MCO for the Outcome Metrics milestone within 30 days of receipt of the Outcome Metrics Report.	Not later than 30 days after receipt of payment from EOHHS, MCO shall make payment for the achieved milestone to the AE.
Developmental Milestones: Variable Percentage Allocations Based on the HSTP Project Plan	Submission of the HSTP Project Plan shall trigger the standard quarterly payment schedule. EOHHS shall pay MCO quarterly based upon the projected timeline for achievement of milestones documented in the HSTP Project Plan. Quarterly payments for milestones	Within 30 days of approving an AE milestone achievement based on satisfactory evidence, MCO shall make payment for the achieved milestone to the AE.

	targeted for achievement in a quarter shall be made no later than the last day of that quarter.	
--	---	--

- **Basis for AEIP Payments by the Contractor to the AE**

Based on the actions of the Contractor's Review Committee and in accordance with the schedule set forth in the AEIP agreement, the Contractor will review the AE's performance in meeting milestones and, based on achievement of milestones, authorize timely payments to the AE as set forth in the table above.

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

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

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

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

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

- **Reporting to EOHHS on the Actions of the Review Committee and 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 and the actions of the Review Committee in review and approval or denial of payments
 - The Contractor must certify in this report that an AE has met its approved milestones as a condition for MCO payment of associated AEIP funds to the AE. The Contractor will, in each report, document progress on identified milestones for each AE, specific dollar allocation for each milestone, and the amount earned by milestone.
 - Upon EOHHS request, the Contractor will arrange for an in-person review of the processes and actions of the Review Committee. EOHHS reserves the right to suspend payments to the Contractor in the event of non-compliance with requirements and to recoup all unspent funds.
- **Final Settle up with EOHHS**

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

2.08.02.06 MCO Incentive Program Management Pool (MCO-IMP)

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

As set forth in Section 2.08.02.05 (AEIP Program Development, Implementation, and Oversight of AEIP Program), the Contractor is responsible for effective implementation and management of the AE program, including oversight and actions to promote successful AE performance. EOHHS will establish the maximum potential MCO-IMP prior to the start of the TCOC performance period. The MCO-IMP shall be established in accordance with the requirements articulated in *RI EOHHS, Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners*.

Assuming satisfactory Contractor performance, the MCO Incentive Program Management Pool will be up to ten percent (10%) of the Total Incentive Pool. This maximum can be earned provided that the Contractor has more than the minimally required number of contracts with AEs, as set forth in Section 2.08.02.02 (Requirements for Contracting with EOHHS Certified AES) and has executed AEIP contracts not later than August 31, 2018. These funds are intended for use toward advancing program

success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the Contractor and the AEs.

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

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

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

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

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

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

2.08.03 Primary Care Providers (PCPs)

2.08.03.01 PCP Responsibilities

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

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

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

2.08.03.02 Eligible Specialties

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

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

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

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

2.08.03.03 PCP Teams

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

2.08.03.04 PCP Sites

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

2.08.03.05 Certified Nurse Practitioners as PCPs

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

2.08.03.05.01 Advance Practice Registered Nurses (APRN)

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

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

2.08.03.05.02 Physicians Assistants

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

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

2.08.03.06 Member-To-PCP Ratios

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

2.08.03.07 In-Network Self-Referrals

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

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

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

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

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

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

2.08.04 Behavioral Health and Substance Use Disorder Providers

2.08.04.01 Provider Mix

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

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

2.08.04.02 In-Network Self Referrals

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

2.08.05 Substance Use Providers

2.08.05.01 Provider Composition

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

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

2.08.05.02 In-Network Self Referrals

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

2.08.05.03 Transitioning between Non-Network and Network Providers

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

2.08.06 Children's Behavioral Health Services

The Contractor will develop and maintain a network of behavioral health providers to deliver services specific to the needs of children.

2.08.07 Physician/Provider Specialists

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

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

2.08.08 Electronic Visit Verification (EVV)

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

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

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

2.08.09 FQHCs/RHCs

The Contractor shall include FQHCs and RHCs in its network unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to

serve the expected enrollment in a service area without contracting with FQHCs or RHCs.

2.08.10 Department of Health Laboratory

The Rhode Island Department of Health (“DOH”) operates a reference laboratory and relies on this laboratory to monitor the incidence of lead poisoning and contagious diseases throughout the State. To assist in this monitoring process, the Contractor agrees to require its network providers to submit to the Department of Health laboratory all specimens for HIV testing and mycobacteria (TB) analysis. All blood lead screening test samples, including venipuncture samples, should be submitted to DOH laboratory for analysis. All non-screening blood lead samples will be considered diagnostic lead testing and may be sent to any lab licensed by the DOH to perform blood lead analysis. The Contractor also agrees to submit specimens from suspected cases of measles, mumps, rubella, and pertussis when required by the State to facilitate investigations of outbreaks. The Contractor will negotiate fees directly with the DOH laboratory.

2.08.11 Title X Providers

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

2.08.12 School-Based Clinics

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

2.08.13 Mainstreaming

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

2.08.14 Selective Contracting

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

2.08.15 Provider Network Lists

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

2.08.16 Network Changes

The Contractor agrees to notify EOHHS monthly of any changes in its network's composition. The Contractor also agrees to notify EOHHS within three (3) calendar days of any changes to the composition of its provider network that materially affects the Contractor's ability to make available all capitated services in a timely manner. The Contractor agrees to have procedures to address changes in its network that negatively affect the ability of members to access services. The Contractor agrees to provide EOHHS with a transition plan to address any impact on member's access to services including process to address member's transition of care.

The Contractor will give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

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

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

2.08.17 Provider Discrimination

The Contractor may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include an individual or groups of providers in its provider network, it will provide the affected providers with written notice of the reason for its decision.

2.08.18 Networks Related to Indians

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

2.09 SERVICE ACCESSIBILITY STANDARDS

The Contractor will establish and implement mechanisms to ensure that network providers comply with the access and timely appointment availability requirements set forth herein. The Contractor will monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply.

The Contractor agrees to comply with any requests for data from the EOHHS' External Quality Review Organization (EQRO) in the conduct of any access-related focused studies.

2.09.01 Twenty-Four Hour Coverage

The Contractor must provide access to medical and behavioral health services and coverage to members either directly or through their PCP on a twenty-four (24) hours a day, seven (7) days a week basis. The Contractor must educate members on how to access services after regular business hours and on weekends. The Contractor may satisfy this requirement by requiring all PCPs to assume the primary responsibility for 24/7 after hours on call telephone services.

2.09.02 Travel Time

The Contractor will develop, maintain and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State established provider-specific network adequacy standards. The Contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided in the table below. Members may, at their discretion, select a participating provider located farther from their home.

Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home

Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

These network standards include all geographic areas covered by the Contractor. EOHHS may, at its sole discretion, grant the Contractor exceptions to the time and distance standards. The Contractor will request an exception in writing and will provide evidence supporting the request to EOHHS. EOHHS's approval of an exception will be in writing. Should EOHHS permit an exception to these time and distance standards, access to that provider type will be monitored by EOHHS on an ongoing basis and may result in additional reporting requirements for the Contractor. These standards will be published on the EOHHS web site and will be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.

2.09.03 Emergency Medical Services

Pursuant to 42 CFR 438.114^{xxiii}, the Contractor agrees to provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in the Contractor's own facilities or through arrangement, with other providers. The Contractor agrees that services will be made available immediately for an emergent medical condition including a mental health or substance use disorder condition. In accordance with 42 CFR 438.114(d)(1)(I)^{xxiv}, the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, as specified in 42 CFR 438.114(b)^{xxv} as responsible for coverage and payment.

The Contractor must cover and pay for Emergency Services, as defined herein, regardless of whether the provider that furnishes the services has a contract with the Health Plan. The Contractor will reimburse non-contracted providers for emergency services in an amount that is no greater than what would have been paid had the service been paid under FFS. In accordance with 42 CFR 438.114 (d)(1)(ii)^{xxvi}, the Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or Health Plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. A member who has an emergency medical condition, behavioral health or substance use disorder condition as defined herein, may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Contractor may not deny payment for treatment obtained when a representative of the entity instructs the enrollee to seek emergency services. The Contractor may not deny payment for treatment, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily

functions, or serious dysfunction of any bodily organ or part. The Federal and State requirements governing emergency services will be provided to members in a clear, accurate and standardized form at the time of enrollment and annually thereafter.

2.09.04 Appointment Availability

The Contractor agrees to make services available to members as set forth in the requirements below:

Appointment	Access Standard
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within twenty-four (24) hours
Routine Care Appointment	Within thirty (30) calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	Thirty (30) calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within ten (10) calendar days

2.09.05 Post-Stabilization Care Services

Post-Stabilization Care Services will be provided to members in accordance with the definition set forth in Section 1.88 members have the right to receive Post-Stabilization Care Services after they have been stabilized following an admission for an emergency medical condition; provided, however, that the provider of Post-Stabilization Care Services must request prior authorization for those services in accordance with the provisions of this Agreement and the Contractor. The Contractor must pay for Post-Stabilization Care Services if: (1) the Contractor pre-approved such services; (2) the Contractor authorizes those services in accordance with the provisions of the Health Plan; (3) the Contractor did not respond to the request for prior authorization within one hour of the request; (4) the Contractor cannot be contacted; or (5) the Contractor's representative and the treating physician cannot reach an agreement concerning the enrollee's care and the Contractor's physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Plan physician and the treating physician may continue with the care of the patient until a Plan physician is reached or one of the criteria of 42 CFR 422.133(c) is met. The requirements of Federal and State law governing Post-Stabilization Care Services will be provided to members in clear, accurate, and standardized form at the time of enrollment and annually thereafter.

The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: (1) a Health Plan physician with privileges at the treating hospital assumes responsibility for the member's care; (2) a Health Plan physician assumes responsibility for the member's care through transfer; (3) the Contractor's representative and the treating physician

reach an agreement concerning the member's care; or (4) the member is discharged as specified in 42 CFR 438.114 (e).

The Contractor must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the Health Plan as indicated in 42 CFR 422.113^{ix}.

2.09.06 Access for Women

The Contractor will allow women direct access to a women's health care specialist within the Contractor's network or outside the network for women's routine and preventive services. A women's health care specialist may include a gynecologist, a certified nurse midwife, or another qualified health care professional. Enrollment in Medicaid Managed Care does not restrict the choice of the provider from whom the person may receive family planning services and supplies.

2.09.07 Assessment Standards

The Contractor will have assessment standards that comply with the Care Management Protocols in ATTACHMENT Q of this Agreement and are approved by EOHHS.

2.09.08 Health Risk Assessments

For all members, the Contractor will conduct a Health Risk Assessment with the member, caregiver or guardian. The Health Risk Assessment will be used to identify members who require short term care coordination or intensive care management for medical, behavioral or social needs.

The Contractor will: (1) provide the Health Risk Assessment to all members within ninety (90) days of enrollment; and (2) ensure the administration of the Health Risk Assessment to pregnant women and members with complex and serious medical or behavioral conditions within thirty (30) days of the date of identification.

2.09.09 Access for Members with Special Needs

In certain cases, members may have an ongoing clinical relationship with a particular specialist who serves as a principal coordinating physician for a member's special health care needs and who plays a critical role in managing that member's care on a regular basis throughout the year. The Contractor will have policies and procedures whereby the member is ensured facilitated and timely access to such principal coordinating physician. Where this is the case, the Contractor will require communication and collaboration between the PCP and the specialist serving as the principal coordinating physician.

For members with special health care needs determined through an assessment by appropriate health care professionals, consistent with 42 CFR 438.208(c) (2)-(3)^{xxvii}, who need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) and produce a treatment plan as appropriate for the member's condition and identified needs.

2.09.10 EOHHS Affordability Standards

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

2.09.11 High Utilizers

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

2.10 MEMBER SERVICES

2.10.01 General

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

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

Explaining to members the operation of the Health Plan, including the role of the PCP and what

to do in an Emergency or urgent medical situation

Ordering member materials such as Handbooks and Provider Directories

Assisting members in the selection of a PCP

Assisting members with questions regarding benefits and how to access services

Assisting members to make appointments and obtain services

Arranging interpreter services

Handling member complaints, grievances and appeals

Assisting members with coordination of out-of-plan services

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

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

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

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

2.10.02 Toll-Free Telephone Number

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

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

2.10.03 Annual Notification

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

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's services area, including those not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
- Any restriction on the member's freedom of choice of network providers
- Member rights and protections, including those specified in 42 CFR 438.100^{xi}
- Notify all members of their disenrollment rights
- Information on grievance, appeal, and State Fair Hearing procedures, including applicable time frames and the information specified in 42 CFR 438.10(g)(1)^{xii}
- The amount, duration, and scope of benefits available under this Agreement in sufficient detail to ensure that members understand the benefits to which they are entitled
- Procedures for obtaining benefits, including authorization requirements
- The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definition in 42 CFR 438.114(a)^{viii}
 - The fact that prior authorization is not required for emergency services.
 - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
 - The locations of any emergency settings and other locations at which providers and hospital furnish emergency services, urgent care and Post-Stabilization Care Services covered under this Agreement.
 - The member has a right to use any hospital or other setting for emergency care.
- The Post-Stabilization Care Services rules set forth in 42 CFR 422.113(c)ⁱⁱ

- Policy on referrals for specialty care and for other benefits not furnished by the member's PCP
- Cost-sharing, if applicable
- How and where to access any benefits that are available under the Medicaid State Plan, but are not covered under this Agreement, including any cost-sharing and how transportation is provided. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. EOHHS must provide information on how and where to obtain the service.
- Advance directives, as set forth in 42 CFR 438.6(I)(1)
- Additional information that is available on request, including information on the structure and operation of the Health Plan and physician incentive plans as set forth in 42 CFR 438.6(h)^{xxviii}

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

2.10.04 Cultural Competency

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

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

1. Develop policies and procedures for the provision of language assistance services which includes but is not limited to interpreter and translation services and effective communication assistance in alternative formats.
2. Will provide language and cultural competence training to all employees, subcontractors and providers. Training should include the potential impact of linguistically and cultural barriers on members obtaining services.
3. Must give the concerns of members related to their racial and ethnic minority status full attention beginning with the first contact with a member, continuing throughout the care process, and extending to evaluation of care;

4. Must make interpreter/translation services available when language barriers exist and are made known to the Contractor, including the use of sign interpreters for members with hearing impairments and the use of Braille for members with vision impairments; and
5. As appropriate, should adopt cultural competency projects to address the specific cultural needs of racial and ethnic minorities that comprise a significant percentage of its member population.

2.11 PROVIDER SERVICES

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

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

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

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

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

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

2.11.1 Provider Manual

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

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

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

2.12 MEDICAL MANAGEMENT AND QUALITY ASSURANCE

2.12.01 General

The Contractor agrees to comply with all Office of the Health Insurance Commissioner utilization review standards for external appeals, in addition to specific standards described in

this section. A health care professional who has the appropriate clinical expertise in treating the member's condition or disease may make a decision to deny a service authorization request or to authorize a service on the basis of Medical Necessity in an amount, duration or scope that is less than requested.

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

2.12.02 Medical Director's Office

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

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

- Be licensed to practice medicine in the State of Rhode Island and be board-certified, board-eligible, or trained in his or her field of specialty
- Be responsible for the Contractor's UR and QA Committees, direct the development and implementation of the Contractor's internal Quality Assurance Plan, utilization review activities, and monitor the quality of care that members receive
- Be responsible for the development of staff education about the Contractor's policies and procedures on advanced directives
- Be responsible for the development of medical practice standards and protocols for the Contractor
- Oversee the investigation of all potential quality of care problems, including but not limited to member-specific occurrences of possible Health Care-Acquired Conditions and Other Provider-Preventable Conditions in accordance with 42 CFR 447.26^{xxix}, 42 CFR 447,434,438, and 1902(a)(4)^{xxx}, 1902(a)(6)^{xxx}, and 1903^{xxxi}, and possible hospital acquired conditions and recommend development and implementation of corrective action plans.
- Be responsible for the development of the Contractor's medical policies, including the implementation and oversight of evidence-based practice guidelines.

- Be responsible for the Contractor's referral process for specialty and out-of-plan services
- Be involved in the Contractor's recruiting and credentialing activities
- Be involved in the Contractor's process for prior authorizing and denying services
- Be involved in the development and oversight of the Contractor's disease management programs
- Be involved in the Contractor's process for ensuring the confidentiality of medical records/client information
- Be involved in the Contractor's process for ensuring the confidentiality of sexually transmitted infection (STI) appointments and mental health and substance use appointments
- Serve as a liaison between the Contractor and its providers and communicate regularly with the Contractor's providers, addressing areas of clinical relevance including but not limited to:
 - The Contractor's utilization management functions
 - The Contractor's prescription and over the counter drug formulary for Medicaid enrollees
 - Disease management and health promotion programs offered by the Contractor
 - Any prior authorization (PA) requirements
 - Clinical practice guidelines
 - Quality indicators, such as the Contractor's performance on HEDIS® and CAHPS® measures
- Serve as the Contractor's representative on the EOHHS Medical Care Advisory Committee.
- Serve as the Contractor's senior clinical officer, participating in the health plan's development of Alternative Payment Methodologies (APM), including any total cost of care and related quality metrics.
- Provide clinical executive leadership as the Contractor analyzes the outcomes of quality metrics for any Alternative Payment Methodologies, including Accountable Entities.
- Participate in the development of strategies to educate members about health promotion, disease prevention and efficient and effective use of health care benefits

- Be available to the Contractor's medical staff on a daily basis for consultation on referrals, denials, complaints, and problems
- A change in Medical Director requires the Contractor to notify EOHHS of change and transition plan as soon as possible but no later than five (5) business days after MCO becomes aware of staffing change. Transition plan must be included with notification to EOHHS.

2.12.03 Utilization Review and Quality Assurance (UR/QA)

2.12.03.01 General

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

- Conform to 42 CFR 438.340 and 42 CFR 438.210
- Assure that the UR and QA Committees meet on a regular schedule
- Provide for regular UR/QA reporting to the Contractor management and the Contractor providers, including profiling of provider utilization patterns

2.12.03.02 Utilization Review

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

The Contractor will provide standard authorization decision within fourteen (14) calendar days of the request for authorization. The timeframes for standard authorization decisions may be extended by fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and the Contractor can demonstrate how the extension is in the member's interest. The Contractor will comply with all timely and adequate notice

requirements as specified in 42 CFR 438.404(c).

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

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

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

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

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

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

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

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

court order, utilization review activities should occur.

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

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

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

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

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

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

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

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

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

2.12.03.02.01 Drug Utilization Review

The Contractor must operate a Drug Utilization Review program (DUR) that complies with the requirements described in section 1927(g) of the Act. The program must assure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results. The DUR program will be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The DUR will be comprised of three sections: 1) Prospective DUR, 2) Retrospective DUR, and 3) An Educational Program.

Contract is required to comply with H.R. 6 The SUPPORT Act Title 1; Section 1004, which mandates the following:

- Contractor must have automated drug utilization review safety edits for opioid refills
- Automated claims review process to identify refills in excess of State limits
- Monitor concurrent prescribing of opioids, benzodiazepines and/or antipsychotics (Including children's antipsychotics).

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

- Data that is necessary for EOHHS to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than forty-five (45) calendar days after the end of each quarterly rebate period, pursuant to 42 CFR 438.3(s)(2). Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.
- The Contractor will establish procedures to clearly identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from these reports to enable EOHHS to accurately bill for the rebate.
- A detailed description of its drug utilization review program activities to EOHHS on an annual basis.

The Contractor must respond to requests for prior authorization for a covered outpatient drug by

telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy-two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation.

2.12.03.03 Quality Assurance

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

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

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

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

The Contractor agrees to support joint quality improvement projects involving Health Plans and EOHHS.

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

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

The Quality Assurance Plan also will:

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

2.12.03.04 Confidentiality

The Contractor must have written policies and procedures for maintaining the confidentiality of data; including medical records/client information and STI appointment records that conform to HIPAA requirements. The Contractor will have available in its network providers willing to provide confidential family planning and STI services to adolescents.

2.12.03.05 State and Federal Reviews

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

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

2.12.03.06 Practice Guidelines

The Contractor will develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236^{xxxiii} and are based on valid and reliable medical evidence or a consensus of health professionals in the particular field, consider the needs of members, developed in consultation with contracting providers, reviewed and updated periodically as appropriate. The Contractor will disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of

services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

2.12.03.07 Service Provision

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

2.12.04 Care Transitions

The Contractor will require participating network hospitals to measure and self-report to the Contractor, in a format and on a schedule determined by the Contractor, and approved by EOHHS, its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care provider (PCP) about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit.

2.12.05 Provider Credentialing

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

The Contractor may execute the network provider agreement pending the outcome of the

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

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

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

The Contractor must also promptly notify EOHHS in writing of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements.

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

2.13 OPERATIONAL DATA REPORTING

2.13.01 General

The Contractor will comply with all of the reporting requirements established by EOHHS. EOHHS will provide the Contractor with the appropriate reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports. If the Contractor delegates responsibility to a subcontractor, the Contractor will ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements. EOHHS will develop and maintain a *Reporting Calendar and* reporting templates, to be used as a living document of the reporting

requirements. All reports listed in the Reporting Calendar are considered final and Contractor is responsible for submitting reports per the deadline in the Reporting Calendar on the date it is due. Further reporting policies and procedures in *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Reporting Penalties: Policy and Procedures for Managed Care Core Contract*.

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

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

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

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

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

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

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

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

2.13.02 Encounter Data Reporting

2.13.02.01 Definitions

- (1) Encounter Data: The record of a member receiving any item(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other risk basis payment methodology.
- (2) Accurate Claims: All fields reflect the service provided and paid and are completed per the data submission guideline and State's companion guide.
- (3) Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection.

2.13.02.02 General Requirements

Pursuant to 42 CFR 438.242(c), the Contractor will submit to EOHHS complete, accurate, and timely encounter data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangement. The Contractor will submit encounter data monthly and in compliance with the EOHHS guidance document "*Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance*". EOHHS reserves the right to make changes to the guidance document at any time. The Contractor is expected to implement all changes within ninety (90) calendar days of notification. The Contractor is solely responsible for submitting all subcontractor encounter data in compliance with EOHHS' encounter data requirements.

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

The Contractor is responsible for collecting, monitoring, submitting and ensuring the accuracy of all 837 submissions and subsequent 277CA reports. The Contractor will submit complete, accurate, and timely encounter data for all services that it, or its subcontractors, have incurred a financial liability within thirty (30) business days of the end of the month in which the liability

was incurred. The Contractor will ensure that ninety-eight percent (98%) of submitted encounters are accepted and do not reject, upon initial submission.

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

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

2.13.02.04 Data Validation

The Contractor agrees to reconcile encounter data, including that of its subcontractors, and to attest to its accuracy with each submission. The Contractor agrees to assist EOHHS in its validation of utilization data by making available a sample of medical records and a sample of its claims data upon request.

The Contractor will submit monthly reports that summarize file submission status by vendor, line of business and fiscal year in a format determined by EOHHS. The report will include, at a minimum:

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

The Contractor will submit documentation and explanation with these reports if the denial rate is greater than two percent (2%) between and among the total value for categories 1-3 above for data outside of timely submission or correction timeframes described herein.

2.13.02.05 Participation in Encounter Data Meetings

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

2.13.02.06 Penalties for Non-Compliance

At the discretion of EOHHS, the Contractor may be subject to monetary penalties if the

encounter denial rate exceeds two percent (2%). EOHHS may assess the following penalties:

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

2.13.03 Grievance and Appeals Data

The Contractor agrees to submit reports in the appropriate format and timetables identified by EOHHS within this contract and Reporting Calendar. The Contractor agrees to submit quarterly reporting for Complaints, Grievance and Appeals submitted to the Plan. Reports will be inclusive of all Lines of Business identified in this contract. This report is due no later than thirty (30) days after the end of the reporting quarter as specified in the Reporting Calendar.

The Contractor will provide the following with each record of a grievance or appeal:

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

2.13.04 EOHHS Quality Assurance Data

The Contractor agrees to make available internal quality assurance reports periodically to EOHHS, as EOHHS may specify. The Contractor also agrees to perform medical record abstracts in selected quality assurance areas, at a minimum of four (4) such areas for Rite Care

including one directed at Children with Special Health Care Needs, one (1) such area for Rhody Health Partners Members and, in any contract year, to be specified by EOHHS, for use in external quality review. The precise methodology for these abstracts will be provided to the Contractor by EOHHS. The Contractor agrees to work cooperatively with EOHHS in developing and implementing this methodology.

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

2.13.05 Member Satisfaction Report

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

2.13.06 Provider Satisfaction Report

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

2.13.07 Fraud and Abuse Reports

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

As indicated in 42 CFR 455.17 the report will indicate at minimum: (1) the number of complaints of fraud and abuse that warranted preliminary investigation, and (2) for each case of suspected provider fraud and abuse that warrants a full investigation. For the latter case, the Contractor will report the following:

- the provider's name and number
- the source of the complaint
- the type of provider
- the nature of the complaint

- the approximate range of dollars involved
- the legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred

2.13.07.01 Member Fraud and Out of State Report

The Contractor will provide monthly reports on any out of state pharmacy activity. Additionally, the Contractor will submit a report of members it has determined to have an out of state address. In the case of members utilizing an out of state pharmacy, EOHHS requires the Contractor to do research necessary to establish a pattern that is suggestive of out of state residency. An example includes learning that a member has picked up maintenance medications at an out of state pharmacy for three (3) or more consecutive months.

2.13.08 RIte Share Reporting

If the Contractor has an active non-Medicaid product, the Contractor will provide claims-based data to EOHHS for any RIte Share Member enrolled and identified by EOHHS; provided however that nothing in this Section nor in any other provision of this Agreement will be interpreted to require the Contractor to participate in RIte Share.

2.13.08.01 Recovery Reporting

The Contractor, and all subcontractors, must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.

2.13.09 Presentation of Findings

The Contractor agrees to obtain EOHHS's approval prior to publishing or making formal public presentations of statistical or analytical material based on its Member enrollment.

2.13.10 Health Insurance Portability and Accountability Act Requirements (HIPPA)

The Contractor will comply with the operational and information system requirements of

HIPAA, including issuance of applicable certificates of credible coverage when coverage is terminated, and will report requested data to EOHHS or its designee.

2.13.11 Certification of Data

The Contractor agrees to certify the data submitted. The Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's CEO or CFO must certify the data. The certification must attest, based on best knowledge, information, and belief, as follows:

- To the accuracy, completeness and truthfulness of the data.
- To the accuracy, completeness and truthfulness of the documents specified by the State.

The Contractor must submit the certification concurrently with the certified data.

2.13.12 Patient Protection and Affordable Care Act

The Contractor will comply with all compliance standards and operating rules of the Patient Protection and Affordability Care Act (PPACA) and will report data as requested by EOHHS or its designee on a timely basis.

The Contractor will provide EOHHS with quarterly pharmacy claims information with respect to Drug Rebate Equalization (DRE) in a format that is compliant with CMS published guidelines and approved by EOHHS.

2.13.13 All Payer Claims Database

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

2.14 GRIEVANCE AND APPEALS

2.14.01 General

EOHHS has established a Grievances and Appeals function through which members can seek redress against Health Plans, and through which Health Plans can seek to disenroll members who are habitually non-compliant or who pose a threat to Health Plan employees or other members. The grievance system includes a grievance process, an appeals process, an external appeal (medical review) process and access to the State's Fair Hearing system. For its part, the Contractor will have written policies and procedures conforming to EOHHS requirements for resolving member complaints and for processing grievances, when requested by the member or when the time allotted for complaint resolution expires. Such procedures will not be applicable to any disputes that may arise between the Contractor and provider regarding the terms, conditions, termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers.

The Contractor is required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

The record of each grievance or appeal must contain, at a minimum, all the following information:

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

The record must be accurately maintained in a manner accessible to the state and available, upon request, to CMS.

2.14.02 Adverse Benefit Determination

An adverse benefit determination means: (1) whether or not a service is a Covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, as defined Section 2.12.03 of this Agreement (6) the failure of the Contractor to act within the timeframes required by the Rhode Island Medicaid Managed Care Grievance and Appeals Process and in Section 0 of this Agreement or (7) the denial of a member's request to

dispute a financial liability.

A Notice of Adverse Benefit Determination must be in writing and must explain:

- The action that the Contractor, or its agents, has taken or intends to take.
- The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The member's or provider's right to file an appeal with the Contractor, including information on exhausting the Contractor's one level of appeal, the right to an external appeal (medical review), and the right to request a State Fair Hearing.
- The procedures for exercising the rights in this section.
- The circumstances under which expedited appeal resolution is available and how to request it.
- The member's rights to have covered benefits continue pending resolution of the appeal and the final decision of EOHHS. How to request that benefits be continued and the circumstances, consistent with state policy, under which the members may be required to pay the costs of these services.

The Contractor may mail notice of adverse benefit determination on the date of the action when:

- The Contractor has factual information confirming the death of the member;
- The member submits a signed written statement requesting service termination;
- The member submits a signed written statement including information that requires service termination or reduction and indicates that he or she understands that service termination or reduction will result;
- The member has been admitted to an institution where he or she is ineligible under the plan for further services;
- The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
- A change in the level of medical care is prescribed by the member's physician;
- The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act; or
- The transfer or discharge from a facility will occur in an expedited fashion.

The Contractor must notify requesting providers and give members written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than the requested authorization. The Contractor must give members timely and adequate notice of an adverse benefit determination in writing as expeditiously as the member's condition requires and consistent with timeframes pursuant to 42 CFR 438.404(c). Contractor may extend the adverse benefit determination timeframe for standard authorization decisions that deny or limit services for up to fourteen (14) additional calendar days if either the member or the provider request the extension, or the Contractor justifies a need for additional information and shows that the extension is in the member's best interest. For prior authorizations for outpatient drugs, the Contractor must respond to requests by telephone or other telecommunication device within twenty-four (24) hours of the request. In addition, the Contractor must ensure a seventy-two (72) hour supply of the requested covered outpatient drug is dispensed in an emergency situation.

If the Contractor has facts indicating that an adverse benefits determination should be made because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources, the Contractor may mail the notice of adverse benefit determination as few as five (5) days prior to the date of action. The Contractor shall provide a notice of adverse determination on the date of the determination when the action is a denial of payment.

The Contractor will also meet the requirements in 42 CFR 438.10 regarding information provided to enrollees. Written materials must use easily understood language and enrollees must be informed that alternative formats are available for those with special needs including those who are visually impaired or have limited reading proficiency. All written materials must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information per 42 CFR 438.71 (a).

2.14.03 Health Plan Grievance and Appeals Process

The Contractor's policies and procedures for processing grievances must permit a member, provider or authorized representative, acting on behalf of the member and with the member's written consent, to file a grievance with the Contractor at any time. The timeframe for resolution is ninety (90) calendar days from receipt of the grievance as provided in Rhode Island Medicaid Managed Care Grievance and Appeals Process.

The Contractor's policies and procedures for processing appeals must permit a member, provider or authorized representative acting on behalf of the member and with the member's written consent, to file an appeal of a notice of adverse benefit determination within sixty (60) calendar days from the date on the Contractor's notice.

In handling grievances and appeals, the Contractor must:

- Give members any reasonable assistance in completing forms and taking procedural steps, including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

- Allow members to file grievance or appeal verbally which must be confirmed in writing to establish the earliest possible filing date unless there is a request for an expedited appeal.
- Provide members with an acknowledgment of receipt of each grievance and appeal within five (5) calendar days.
- Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making and they are not subordinates of any such individual.
- Ensure that decision makers on grievance and appeals are health care professionals who have appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if they are involved in deciding on any of the following: (a) an appeal of a denial that is based on lack of medical necessity, (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal that involves clinical issues
- Ensure that that decision makers on grievances and appeals consider all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
- Provide the member and his or her representative the member case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor considered during the appeals process. The Contractor will provide this information to the member free of charge and sufficiently in advance of the resolution timeframes for the appeals as specified in 42 CFR 438.408 (b) and (c). Under certain circumstances, certain categories of medical records and other documents may not be available to the member based on the type of record including, but not limited to, mental health records; and (d) include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate.

The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires but not to exceed ninety (90) calendar days from the date that the Contractor received the grievance. For resolution of each standard appeal, the Contractor must provide written notice of the disposition within thirty (30) calendar days from the time the Contractor receives the appeal. The timeframes for both grievances and appeals resolution may be extended by up to fourteen (14) calendar days if the member requests an extension or if the Contractor shows (to the satisfaction of EOHHS upon request) that there is need for additional information and how the delay is in the member's best interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;

- Within two (2) calendar days, give members written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

Each written notice of determination must include the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members, the right to a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

2.14.04 Expedited Resolution of Appeals

The Contractor must also establish and maintain an expedited review process for appeals. An expedited review is permitted when the Contractor determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Expedited appeals must be resolved within seventy-two (72) hours of receipt of the appeal. The member may submit a verbal request for an expedited resolution of appeal. The member does not need to follow an oral request for an expedited resolution of appeal with a written request. The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

The Contractor may extend the timeframe for an expedited appeal by fourteen (14) days if the member, the member's representative or the provider request an extension or the Contractor can show (to the satisfaction of EOHHS, upon EOHHS' request) that there is need for additional information and that the extension is in the member's interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following:

- Make reasonable efforts to give the member prompt oral notice of the delay;
- Within two (2) calendar days give the member's written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision;
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

The Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or who supports a member's request.

If the Contractor denies the request for an expedited appeal, it must transfer the appeal to the timeframe for standard resolution, make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

In the case that the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process. The member may initiate a State Fair Hearing.

Each written notice of determination must include the following:

- The results of the resolution process and the date it was completed.
- For appeals not resolved wholly in favor of the members, the right to a next level appeal, inclusive of an external appeal at no cost to the member; the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the enrollee may not be held liable for the cost of those benefits if the hearing decision upholds the Contractor's notice of adverse benefit determination.
- Information on how to contact the Contractor either in writing or telephone regarding the appeal process.

2.14.05 Continuation of Benefits

As specified in 42 CFR 438.420, the Contractor must continue the member's benefits while an appeal is in process if all the following conditions are met:

- The member files a timely request for an appeal;
- The member files for a continuation of benefits within ten (10) days of the Contractor mailing the notice of adverse benefit determination, or the intended effective date of the Contractor's proposed action;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and

- The authorization period has not expired.

If the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal;
- The member fails to request a State Fair Hearing and a continuation of benefits within ten (10) calendar days after the Contractor sends the notice of an adverse resolution
- A State Fair Hearing decision is adverse to the member.

2.14.06 State Fair Hearing and External Appeal (Medical Review Process)

If the member has exhausted the Contractor's internal appeals procedures and the Contractor upholds the adverse benefit determination, the member, or a provider or representative acting on the member's behalf, may request a State Fair Hearing. The State must grant the request for a State Fair Hearing if the member submits the request within one hundred and twenty (120) calendar days of the Contractor's notice of resolution. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member by the Contractor.

For members who have exhausted the Contractor's internal appeals procedures and the Contractor has upheld the adverse benefit determination, the State also offers and arranges for an external medical review if the following conditions are met:

- The review must be at the member's option and must not be required before or used as a deterrent to proceed to the State fair hearing;
- The review must be independent of both EOHHS and the Contractor;
- The review must be offered at no cost to the member;
- The review must not extend any of the timeframes specified in the contract and must not disrupt the continuation of benefits.

The member must submit a request for an External Appeals (Medical Review) within four (4) months of the Contractor's notice of resolution. The External Appeal (Medical Review) is governed by the Office of the Health Insurance Commissioner (OHIC) under the external appeal procedural requirements pursuant to RIGL 27-18.9-8 of the Benefit Determination and Utilization Review Act and is a level of review which is aside and apart from the State Fair Hearing process. The Member may request either a State Fair Hearing or an External Review or, if desired, both. The External Appeal (Medical Review) can occur simultaneously or consecutively with the State Fair Hearing as long as the request is made within four (4) months of the Contractor's notice of final resolution. The Contractor will execute individual contracts with each OHIC identified Independent Review Organizations (IRO) to permit Medicaid members access to an External Appeal (Medical Review). The Contractor will use the rotational IRO registry system specified by the OHIC Commissioner. The Contractor agrees to submit appeals related reports to both EOHHS and OHIC in a format and template approved by both State Agencies. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination and appeal resolution, The Contractor may recover the cost of the services furnished the member while the appeal was pending, to the extent that they were furnished solely

because of the requirements of 42 CFR 438.420, and in accordance with the policy set forth in 42 CFR 431.230(b).

If the Contractor, State Fair Hearing officer or external reviewer reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

State ensures that any member dissatisfied with a State agency determination denying a member's request to transfer plans/disenroll is given access to a State Fair Hearing.

2.15 PAYMENTS TO AND FROM PLANS

2.15.01 Acceptance of State Capitation Payments

The Contractor will be capitated for all in-plan services, as described in Section 2.06 in the amount specified in ATTACHMENT J, and such reimbursement will be subject to all conditions specified in this Agreement. ATTACHMENT L describes the rate-setting process used and the basis for establishing the rates in ATTACHMENT J.

The monthly capitation rates set forth in ATTACHMENT J will not be subject to change during the effective period therein specified except: (1) by Federal or State law; or (2) to cover additional services not currently included in ATTACHMENT A or to reflect a reduction in covered services; or (3) unless such change has been negotiated in accordance with Section 3.03 of the Agreement. Such change in rates will not be effective until agreed in writing by the parties or, in the event of a change due to (1) above, until written notice by EOHHS to the Contractor.

EOHHS will make Capitation Payments to the Contractor on a monthly basis via electronic funds transfer in the following manner:

- For Rite Care members EOHHS will not pay a SOBRA payment for miscarriages (defined as spontaneous fetal death less than twenty (20) weeks), nor will EOHHS make a SOBRA payment for a pregnancy resulting in induced termination regardless of gestational age.
- For Rite Care and Children with Special Health Care Needs members, on or before the fifth (5th) business day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Health Plan for the present month, as of a date on or about the twenty-fifth (25th) of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during the present month.
- Along with the amount identified in the above paragraph, adjustment will be made for

members for whom an enrollment or disenrollment transaction was made after the 25th day of the next previous month but before the close of the month in question. The adjustment will be based on a daily rate equal to 1/30th of the month rate for each age/sex rate category (rounded to 1/10th of a cent, e.g., \$3.873). A remittance advice will accompany all payments identifying every member, their Medicaid ID number, the number of days paid and total payment and/or adjustments.

- For members whose enrollment lapses for any portion of a month in which a capitation payment was made, due to loss of eligibility, death or other circumstance, EOHHS will adjust its next monthly Capitation Payment to recoup the portion of the capitation payment to which it is due to a refund.
- For Rhody Health Partners members, on or before the last day of every month, the Contractor will receive a roster of individuals projected to be enrolled in or assigned to the Contractor for the following month.
- For Rhody Health Partners members, on or before the fifth (5th) calendar day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during that month.
- For RItE Care members who are pregnant and whose pregnancy results in a live birth or still birth (still birth defined as spontaneous fetal death at greater than or equal to 20 weeks gestation), EOHHS will make a supplemental (SOBRA) payment for delivery as part of its monthly capitation payment on the basis of a valid claim by the Contractor.
- For members with a cost-sharing requirement to the Contractor, the amount of the capitation will be reduced by the portion of the premium, or copayment, which is the responsibility of the member.

The Contractor agrees to accept enrollment information and capitation payments in this manner and will have written policies and procedures for receiving and processing capitation payments.

For RItE Care members on or before the fifth (5th) calendar day of every month, the Contractor will receive capitation payments for individuals projected to be enrolled or assigned to the Contractor for that month, based on the roster provided at the end of the preceding month. These payments will reimburse the Contractor for services rendered to these individuals during that month.

2.15.01.01 Fee Schedule Increase and Adoption of Minimum/Maximum Fee Schedule

EOHHS may require the MCO to adopt a minimum fee schedule for network providers, provide a uniform dollar or percentage increase for network providers or adopt a max fee schedule so

long as MCO retains ability to reasonably manage risk. 42 CFR 438.6(c)(2) sets forth criteria to receive written approval prior to implementation the arrangement must which must be developed in accordance with 42 CFR 438.4.5.

- **Increase to Pediatricians Rates to ensure access to care:**

In order to insure adequate access to primary care for children, EOHHS requires that a minimum fee schedule for participating pediatricians be set at seventy-five percent (75%) of RI Medicare rates for all E&M codes. This increase must be implemented and maintained for the duration of this agreement by the Contractor effective June 1, 2017.

2.15.01.02 Incentive Payments

As part of CFR 42 CFR 438.6, the State has the authority to implement incentive payments to providers. All incentive payments will be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy. Incentive payments are available to both public and private contractors under the same terms of performance. Through this contract the State is implementing certain incentive programs, payments for which will be made directly by Rhode Island Medicaid to the Medicaid MCO based upon EOHHS approval of such arrangements and EOHHS determination of satisfactory compliance with such incentive arrangements. These Incentive Programs include:

- **Rhode Island's Health System Transformation Program**

CMS has approved amendments to Rhode Island's 1115 Demonstration Waiver enabling EOHHS to proceed with its Health System Transformation Project. Contracted Medicaid MCOs are anticipated to be full partners in HSTP to support and incentivize a critical transformation of RI's system of care. There are two specific incentive related components to this program: (a) the Hospital and Nursing Home Incentive program and (b) the HSTP related Medicaid Incentive Infrastructure Program.

These incentive payments are not to be considered part of the medical component of the premium payment made to the Health Plan and will not be included in any risk/gain share calculations between EOHHS and the Contractor. Neither the MCO-IMP incentive payment to the Contractor by EOHHS nor the AEIP incentive payments made by the Contractor to AEs will be included in any risk/gain share calculations or in any total cost of care calculations pertaining to arrangements with AEs. Total incentive payment inclusive of performance goal and/other provider performance-based payments cannot exceed five percent of capitation.

- **Hospital and Nursing Home Incentive Program**

Note that this contract pertains to the Hospital Incentive program only. EOHHS will

address the Nursing Home portion of the Incentive program elsewhere.

To implement the Hospital Incentive portion of HSTP, EOHHS developed and implemented the Hospital Incentive program, inclusive of data collection, performance measurement and scoring, dollar allocation for payment to providers, and funds distribution. The program included one-time payments made to hospitals by contracted MCOs with total payments not exceeding \$13.5 million and with all payments to be made on or before December 31, 2017.

EOHHS has provided the Contractor with specific provider performance reports that details each specific hospital, the performance measure, baseline for each measure, identified benchmark, performance score, and dollars allocated for each measure.

In advance of the Contractor's payments to hospitals, the Contractor received payment from EOHHS in the amount and schedule set forth stipulated in the provider performance report. The Contractor used this report to make the incentive payment to each applicable hospital on a scheduled basis as determined by EOHHS.

The total amount to be paid for each provider will be equally distributed among each contracted Health Plan. Payments to the applicable hospitals as specified in the provider performance report are based on demonstrated achievement of pre-determined performance benchmarks for established measures; if a hospital does not achieve the benchmark, no payment will be made.

- **Medicaid Infrastructure Incentive Program**

A central feature of the Health Systems Transformation Program is the advancement of Accountable Entities through contractual partnerships with MCOs participating in the Medicaid managed care program. Such partnerships must comply with the provisions set forth in Section 2.08.02 ("Contracting with EOHHS Certified Accountable Entities") of this Agreement.), inclusive of Sections 2.08.02.01 through 2.08.02.06 which specifically address the terms and conditions for HSTP based incentive arrangements between the Contractor and AEs and between EOHHS and the Contractor.

2.15.01.03 General

EOHHS believes that one of the advantages of a managed care system is that it permits Health Plans and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. However, the Contractor agrees to make timely payments to both its contracted and non-contracted providers, subject to the conditions described below. To ensure access and quality of care for its members to behavioral health services, the Contractor agrees to make timely and accurate payments to its behavioral health providers. The Contractor also agrees to abide by the special reimbursement provisions for FQHCs and RHCs described below.

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

Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers).

2.15.01.04 Retroactive Eligibility Period

The Contractor will not be responsible for any payments owed to providers for services that were rendered prior to a member's enrollment, even if they fell within any applicable period of retroactive eligibility for Medicaid.

2.15.01.05 In-Network (Contracted) Services

The Contractor will be responsible for making timely payment and meet the requirements of 42 CFR 447.45^{xxii} and 42 CFR 447.46^{xxxv} for Medically Necessary, Covered Services rendered by in-network providers when:

- Services were Emergency Services
- Services were rendered under the terms of the Health Plan's contract with the provider
- Services were prior authorized

A claim means (1) a bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill. A clean claim means one that can be processed without additional information from the provider of service or from a third party. It includes a claim with errors originating in the State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. Timely payment means within thirty (30) days of receipt of a "clean claim" for reimbursement. Timely payment is judged by the date that the Contractor receives the claim as indicated by its date stamped on the claim and the date of payment is the date of the check or other form of payment.

Under these terms, the Contractor will not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of the Contractor's contract with the provider.

The Contractor will make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e)^{xxxvi}.

2.15.01.06 Out-of-Network and Out-of-State Providers

The Contractor will be responsible for making timely payments to out-of-network providers for Medically Necessary, covered services when:

- Services were Emergency Services
- Services were prior authorized

Under these terms, the Contractor will not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of the Contractor's contract with the provider.

For services provided to eligible and enrolled members, claims for services from a provider may be paid at established Rhode Island Medicaid fees that are in effect at the time of service when the following two conditions are met, and the provider does not have an existing agreement with the Contractor:

- a) The provider must be an out-of-State provider, and
- b) The provider must be out-of-network

For services provided to members, claims from out-of-network providers may be paid at established Rhode Island Medicaid fee-for-service rates that are currently in effect at the time of service or at a fee negotiated between the Contractor and the provider of services.

Any provider of Emergency Services that does not have in effect a contract with the Contractor must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the enrollee received Medicaid other than through enrollment under this Agreement.

The Contractor will make payment for Post-Stabilization Services in conformance with 42 CFR 438.114(e)^{xxxvi}.

2.15.01.07 FQHCs/RHCs

If the Contractor includes FQHCs or RHCs in its network, it agrees to address cost issues related to the scope of services rendered by these providers and must reimburse them either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. The Contractor agrees to reimburse FQHCs/RHCs at a rate not less than that paid for comparable

services provided by non-FQHC/RHC based providers.

2.15.01.08 Hospital Services

The Contractor will be required, to implement reforms required by Rhode Island State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) which stipulates certain requirements for payments to hospitals.

EOHHS recognizes that providing Long Acting Reversible Contraceptive Devices (LARCs) immediately post-partum in a hospital setting and prior to discharge has been shown to be effective in prolonging inter -birth intervals and preventing pre-term birth. The Contractor is required to reimburse providers for LARCs outside of the global fee for labor and delivery when the device is inserted post-partum in a hospital setting. The Contractor will reimburse separately for the LARC, outside of the global fee for labor and delivery.

The Contractor will provide quarterly reporting regarding payments as stipulated by R.I. General Law Chapter 40-8, Section 40-8-13.4.

2.15.01.09 Nursing Homes

The Contractor will negotiate the reimbursement rates with nursing home providers. The Contractor will establish rates that consider the acuity of care provided to members as well as contain quality indicators. As a condition for payment, the Contractor must ensure that the Nursing Home has met all federal and state OBRA/PASRR requirements for all individuals seeking admission or readmission to a nursing home, subsequent to the provisions in 42 CFR 483.100-138 and Rhode Island Rules and Regulations for Medicaid Section 0378.05. EOHHS will approve the reimbursement method used to reimburse nursing facilities.

2.15.01.10 Liability During an Active Grievance or Appeal

The Contractor will not be liable to pay claims to providers if the validity of the claim is being challenged by the Contractor through a grievance or appeal unless the Contractor is obligated to pay the claim or a portion of the claim through its contract with the provider.

2.15.01.11 Limit on Payment to Other Providers

In accordance with 42 CFR 438.60^{xxxvii}, no payment will be made for services furnished by a provider other than the Contractor or by one of the Contractor's participating providers, if the services were available under the contract.

2.15.01.12 Physician Incentive Plans

The Contractor will not place physicians at substantial financial risk for services which avoid costs by limiting referrals to specialty care or reduce medically necessary services to members. Also, the Contractor will not place physicians at substantial financial risk for services that are not provided by the physician or physician group. The Contractor will comply with Federal definitional, operational, and reporting requirements governing physician incentive plans as defined at 42 CFR 422.208^{xxxviii} and 42 CFR 422.210, 42 CFR 434.70 and 42 CFR 1003.

2.15.01.13 Actuarial Basis

The actuarial basis in the rate setting process for the computation of capitated rates is provided in ATTACHMENT J of this Agreement.

2.15.01.14 Prohibition on Restocking and Double Billing of Prescription Drugs

To conform to Section 1903(i)(10) of the Social Security Act, 42 U.S.C. 1396b(i), payment will not be made with respect to any amount expended for reimbursement to a pharmacy for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than with respect to a reasonable restocking fee for such drug).

2.15.01.15 Payment Adjustment for Provider Preventable Conditions

The Contractor will meet the requirements of 42 CFR 447.26^{xxxix}, Subpart A^{xl}, 42 CFR 434.6(a)(12), 42 CFR 438.3(g); 42 CFR 447.26(d) and sections 1902(a)(4), 1092(a)(6) , and 1903^{xxxi}, with respect to non-payment for provider preventable conditions for Health Care-Acquired Conditions and Other Provider-Preventable Conditions. Specifically, this includes the development of the capacity for claims systems to recognize and reject/deny procedures coded with the modifiers PA (surgical or other invasive procedure performed on the wrong body part), PB (surgical or other invasive procedure performed on the wrong patient), and PC (wrong surgical or invasive procedure performed on a patient). The disallowance of reimbursement for OPPCs applies to freestanding and hospital-based clinics, freestanding and hospital-based ambulatory surgery services, office-based settings and emergency departments that submit claims to the Contractor. The Contractor will require its contracted providers to identify and report provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to member for which Medicaid payment would otherwise be available. EOHHS will recoup all funds related to the inappropriate payment by the Contractor for provider preventable conditions, health acquired conditions and never events. EOHHS, at its discretion, will require Contractor to report claims paid to providers and facilities for provider preventable conditions and/or hospital acquired conditions.

2.15.01.16 Health Insurer Fee

If applicable, the Contractor may be subject to the Health Insurer Fee (HIF) under Section 9010 of the Patient Protection and Affordable Care Act of 2010. The HIF is imposed on qualifying health insurers based on their premiums in the previous year. If the Contractor is subject to the HIF, EOHHS will pay the Contractor's HIF retrospectively.

The amount due to the eligible Contractor shall be determined based on the Contractor's final Form 8963 filing, the final notification of the HIF amount owed by the Contractor received from the United States Internal Revenue Service, and any additional supporting documentation as requested by EOHHS. If Congress issues a moratorium for the HIF in any given year, EOHHS will not issue any payment to the Contractor. Payment is contingent on the availability of State funds.

2.15.02 Cost Sharing

Any cost sharing imposed on Medicaid enrollees is in accordance with 42 CFR 447.50^{xli} through 42 CFR 447.56^{xlii}.

EOHHS will have sole responsibility for determining the cost-sharing responsibilities for members. EOHHS will notify members of their cost-sharing responsibilities including the amounts of cost-sharing. EOHHS will notify the Contractor of a member's cost-sharing responsibilities, if applicable.

The Contractor will have policies, practices and procedures to ensure that cost-sharing responsibilities, if applicable, are met. Members are required to pay providers monthly of their cost-sharing responsibilities, if applicable.

2.15.02.01 General RItE Care Cost-Sharing

The RItE Care program has no cost-sharing requirements (premiums and copayments) for any member. In accordance with 42 CFR 438.106, the Contractor agrees that RItE Care members are held harmless from fees, including the debts of the Contractor in the event of the Contractor's insolvency or the Contractor's failure to pay a health care provider or supplier of covered services or goods and will not bill or attempt to collect any other fee from RItE Care members.

2.15.02.02 Exemption for Indians Served by Indian Healthcare

The Contractor will exempt Indians from payment of enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through Contract Services, HIS (CHS). The Contractor must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by

the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

2.15.03 Stop Loss

Stop-loss provision means the mechanism by which EOHHS will reimburse Contractor for the expenses of specific benefits exceeding limits referenced in this Agreement . Stop-loss provisions will apply on a calendar year basis for Contract Period #1 (ending June 30, 2018) and Contract Period #2 (beginning 7/1/2018) and for any subsequent Contract Periods, as defined in ATTACHMENT N, Special Terms and Conditions, Sections 12 and 13 of this Contract.

2.15.04 Third-Party Liability

Third-Party Liability ("TPL") refers to any individual entity (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of member's health coverage including subrogation. Under Section 1902(a) (25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

The Contractor agrees to take responsibility for identifying TPL for members and reporting such TPL source to EOHHS within five (5) calendar days of the source becoming known to the Contractor, in a format determined by EOHHS. The Contractor will collect and retain all Third-Party Liability collections.

The Contractor agrees to cooperate with EOHHS in the implementation of RI General Laws 40-6-9.1 by participating in the matching of data available to EOHHS and to the Contractor through an electronic file match. The matching of such data is critical to the integrity of the Medicaid program and the use of public funds. Requests made of the Contractor by EOHHS will be made at such intervals as deemed necessary by EOHHS to participate in the data matching. The Contractor will respond with the requested data within five (5) business days.

2.15.05 Reinsurance

The Contractor will be required to obtain reinsurance coverage from a source other than EOHHS. Proof of such reinsurance is a condition of contract award. EOHHS reserves the right to review the Contractor reinsurance coverage and to require changes to that coverage in the form of lower thresholds if considered necessary based on the Contractor's overall financial condition. The Contractor may not change the thresholds from those in ATTACHMENT K of this Agreement without the prior written consent of EOHHS.

2.15.06 Reserving

As part of its accounting and budgeting function, the Contractor will establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Contractor also will reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and reported but unpaid claims (RBUCs). As part of its reserving methodology, the Contractor will conduct “look backs” at least annually to assess its reserving methodology and make adjustments as necessary.

2.15.07 Claims Processing and MIS

The Contractor agrees to have claims processing system and Management Information System (MIS) sufficient to support the provider payment and data reporting requirements specified elsewhere in this contract. The Contractor also will be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of members.

2.15.08 Audits

In accordance with 42 CFR 438.242 and 438.602 (e), EOHHS, or its designees will conduct no less than once every three (3) years, with reasonable notice, any and all audit functions necessary to verify proper invoicing by the Contractor for provision of services, proper payments by EOHHS to the Contractor, and proper identification of TPL in accordance with this contract.

In the event that audit liabilities arising from any discrepancies in payments are discovered during the course of such audits, the net effect of which resulted in an overpayment to the Contractor, EOHHS may either:

- Make a demand for repayment of overpayment amount within thirty (30) calendar days
- Offset the amount of overpayment from invoices submitted to provide for payment and/or by the next monthly payment cycle.
- Refer the matter to the Department of Attorney General Medicaid Fraud Unit for investigation and/or seek interest in funds pursuant to RI General Laws Section 40-8.2-22.

In the event that audits discover underpayment to the Contractor, EOHHS will process a corrective payment within thirty (30) calendar days.

Any dispute or controversy encountered pursuant to this provision will be resolved pursuant to the guidelines specified herein.

2.15.09 Disproportionate Share Payments to Hospitals

The State will retain responsibility for disproportionate share payments to hospitals, if any. The Contractor will not be responsible for these payments.

2.15.10 Performance Goals

The purpose of performance measures is to ensure the Contractor provides eligible Medicaid beneficiaries with services that are high quality, accessible and promote positive health outcomes in a cost efficient and effective manner. The performance measures support the EOHHS Comprehensive Quality Strategy, Population Health Goals, and EOHHS vision, values, goals and priorities. The measures represent areas of opportunity for improvement and align with the RI Aligned Measure Set and the CMS Core Measures.

The performance measure program is for reporting purposes and is based on established benchmarks from the Quality Compass®. The goal is for the Contractor to achieve the benchmarks between the 75th and 90th percentile rate. The percentile rate measure should improve year to year. When the MCO consistently achieves the 90th percentile, or higher, on any given measure reporting requirements may be adjusted. A corrective action plan will be implemented for performance measures that fall below a preset acceptable level of achievement. If performance does not improve with the implementation of a corrective action plan, EOHHS can impose further corrective action as deemed appropriate.

Performance measures will be announced to the Contractor via electronic mail on an annual basis. The performance measure sets are subject to change based on performance in the prior year's HEDIS and performance measures, as well as changes to the HEDIS, CMS Core Measure Sets, and/or the RI Aligned Measure Set.

2.15.11 Prohibited Payments

To conform to Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396 (i)) the Contractor is prohibited from paying for: 1) organ transplants unless the State Plan provides, and the Contractor follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees; 2) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; 3) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; 4) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act, 5) an item or service (other than an

emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished through the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act, 6) an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

2.16 HEALTH PLAN FISCAL STANDARDS

2.16.01 General

The Department of Business Regulation regulates the financial stability of all licensed Health Plans in Rhode Island. The Contractor, therefore, agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific Medicaid Managed Care standards described in this Section.

2.16.02 Financial Benchmarks

The success of the Rhode Island Medicaid Managed Care program is contingent on the financial stability of participating Health Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of Health Plans. The Contractor must provide documentation on a regular basis as outlined in this contract that the Contractor is financially solvent, has the capital, and has the financial resources and management capability to operate under this risk-based contract. The Contractor will demonstrate to EOHHS that it is able to meet the solvency requirements set forth through the Rhode Island Office of the Health Insurance Commissioner (OHIC).

The Contractor agrees to provide all the information necessary for calculating benchmark levels. The Contractor also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

2.16.03 Financial Data Reporting

The Contractor agrees to comply with the *Rhode Island Medicaid Managed Care Health Plan Financial Reporting Program*. Such compliance includes, but is not limited to, the submission of the following reports:

- Annual NAIC Financial Statements, including Risk Based Capital Reports;

- The Contractor's Annual Audited Financial Statements;
- The Contractor's Annual Report to Owners, Shareholders, members, and Others;
- Quarterly NAIC Financial Statements;
- Monthly Financial Statements;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Claims Reinsurance Coverage and attachment points;
- Where applicable, evidence that the parent Company provides one hundred percent (100%) of subsidiary's financial backing.
- The Contractor's Risk/Gain Share Statements;
- Stop Loss Statements;
- Annual MLR Statement using the *Medicaid Managed Care Program: Medical Loss Ratio Calculation* workbook and template provided by EOHHS.
- AE Shared Savings Financial Performance Report
- Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Contractor's financial position or performance.

The Contractor agrees to comply in a timely and complete manner with all financial reporting requirements associated with the Accountable Entity (AE) Initiative.

2.16.04 Audit

In the case where the Agreement amount identified in Section 0 (Payments to and from Plans) is at least twenty-five thousand dollars (\$25,000) in any year, the Contractor must submit an acceptable audited financial statement prepared by an independent auditor within twelve (12) months of the end of the Contractor's fiscal year. The audit must provide full and frank disclosure of all assets, liabilities, changes in fund balances, and all revenues and expenditures.

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

The State retains the right to conduct, or cause to be conducted, specific audits. These audits may be conducted upon reasonable notification to the Contractor, and the audits would focus on matters related, but not limited, to:

- Invoicing by the Contractor for provisions of services;
- Payment to the Contractor by the State;

- Compliance with any of the terms and conditions of the Contract or Contract Amendments.

2.16.03.01 Financial Data Reporting System

EOHHS is implementing and requiring Contractors to report through a new Financial Data Reporting System (FDRS). The FDRS will utilize specific templates to be populated by the Contractor. The FDRS will capture the Contractor's membership, benefit expenses, including general ledger adjustments, sub-capitated arrangements, reinsurance arrangements, reserves, benefit expense recoveries and administrative costs for each Premium Rating Group. Reconciliation of the submitted information to the Contractor's NAIC financial statements will be required. FDRS requirements will include data for the contract period beginning July 1, 2019.

These requirements will be added to Contractor's Reporting Calendar as specified in Section 2.13.01 of this Contract.

2.17 RECORDS RETENTION

2.17.01 General

The Contractor agrees to maintain and require its subcontractors to maintain books and records relating to Medicaid Managed Care services and expenditures covered under this Agreement, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, grievance and appeals records, medical loss ratio records and prescription files for a period of no less than ten (10) years.

The Contractor also agrees to comply with all standards for record keeping specified by the State. Operational data and medical record standards are described below. In addition, the Contractor must agree to permit inspection of its records under the terms specified in Section 2.15.07 (Claims Processing and MIS) and in ARTICLE III: CONTRACT TERMS AND CONDITIONS of the Agreement.

2.17.02 Operational Data Reports

The Contractor agrees to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information. Financial records must be retained for at least ten (10) years.

2.17.03 Medical Records

The Contractor agrees to preserve and maintain all medical records for a minimum of ten (10) years from expiration of this Agreement.

If records are related to a case in litigation, then these records should be retained during litigation and for a period of seven (7) years after the disposition of litigation.

2.18 COMPLIANCE

2.18.01 General Requirements

In accordance with 42 CFR 438.608^{xliii}, the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the State and the Contractor, will have administrative and management arrangements, including a mandatory written compliance plan, which are designed to guard against fraud and abuse. An electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to the EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter.

The Contractor's compliance plan must address the following requirements:

- The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract
- Effective training and education for the compliance officer, the Contractor's senior management, and the organization's employees for the federal and state standards and requirements under this contract.
- Effective lines of communication between the compliance officer and the Contractor's employees.
- Enforcement of standards through well-publicized disciplinary guideline.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law

enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including change in address and the death of a member
- Provision for prompt response to detected offenses, and for development of corrective action initiatives
- Provisions to implement and verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers are received by member.

2.18.02 Prohibited Affiliations with Individuals Debarred by Federal Agencies

In accordance with 42 CFR 438.610^{xliv}, the Contractor may not knowingly have a relationship with the following:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1) of this section.

The relationships described are as follows:

- (1) A director, officer, or partner of the MCO.
- (2) A person with beneficial ownership of five (5) percent or more of the MCO's equity.
- (3) A person with employment, consulting, or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the State.

2.18.03 Disclosure of the Contractor's Ownership and Control Interest

In accordance with 42 CFR 455.104, the Contractor must submit completed forms documenting full and complete disclosure of the Contractor's ownership and controlling interest, formatted in conformance with requirements established by EOHHS. Disclosures will be due at any of the

following times:

- (1) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
- (2) Upon the managed care entity executing the contract with the State.
- (3) Upon renewal or extension of the contract.
- (4) Within thirty-five (35) days after any change in ownership of the managed care entity. The following information will be disclosed by the Contractor, based on 42 CFR 455.104:
 - (i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity or managed care entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.
 - (ii) Date of birth and Social Security Number (in the case of an individual).
 - (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or managed care entity) or in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest.
 - (iv) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or managed care entity) is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
 - (v) The name of any other disclosing entity (or managed care entity) in which an owner of the disclosing entity (or managed care entity) has an ownership or control interest.
 - (vi) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or managed care entity).

The Contractor must keep copies of all ownership and control interest requests from EOHHS and the Contractor's responses to these disclosure requests. Copies of these requests and the Contractor's responses to them must be made available to the Secretary of the United States Department of Health and Human Services or to the EOHHS upon request. The Contractor must submit copies of the completed disclosure forms to the Secretary of the United States Department of Health and Human Services or to EOHHS within thirty-five (35) days of a written request.

2.18.04 Disclosure by Providers: Information on Ownership and Control

In accordance with 42 CFR 455.104, the Contractor must require each disclosing entity to disclose the following information:

- (i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.
- (ii) Date of birth and Social Security Number (in the case of an individual).
- (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or managed care entity) or in any subcontractor in which the disclosing entity (or managed care entity) has a five (5) percent or more interest.
- (iv) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- (v) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- (vi) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR Section 1001.1001(a)(1).

Any disclosing entity that is subject to periodic certification by the Contractor of compliance with Medicaid standards (such as at the time of initial credentialing and re-credentialing by the Contractor) must supply the information as specified in this section in conformance with requirements established by the EOHHS. Any disclosing entity that is not subject to periodic certification of its compliance within the prior 12-month period must submit the information to the Contractor before entering into a contract or agreement with the Contractor.

Disclosures must also be provided by any provider or disclosing entity at the following times:

- When the provider or disclosing entity submits a provider application;
- When the provider or disclosing entity executes a provider agreement with the State;

- Upon request of the State during the revalidation of the provider enrollment; and
- Within thirty-five (35) days after any change in ownership of the disclosing entity.

Updated information must be furnished to the Secretary of the United States Department of Health and Human Services or to EOHHS at intervals between recertification or contract renewals, within thirty-five (35) days of a written request.

The Contractor will not approve a provider agreement and must terminate an existing provider agreement or contract if the provider fails to disclose ownership or control information as required by this section.

2.18.05 Disclosure by Providers: Information Related to Business Transactions

In accordance with 42 CFR 455.105, the Contractor must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary of the United States Department of Health and Human Services or to EOHHS on request full and complete information related to business transactions.

A provider must submit, within thirty-five (35) days of the date of a request by the Secretary of the United States Department of Health and Human Services or the EOHHS, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than twenty-five thousand (\$25,000) dollars during the 12-month period ending on the date of request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five year period ending on the date of the request.

This information must be submitted by a provider or a subcontractor to the Secretary of the United States Department of Health and Human Services or to the Rhode Island EOHHS within thirty-five (35) days of a written request.

2.18.06 Disclosure by Providers: Information on Persons Convicted of Crimes

In accordance with 42 CFR 455.106, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the provider must disclose the identity of any person who:

- (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of those programs.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR 1001.1001(a)(1).

The Contractor will promptly notify EOHHS in writing within ten (10) business days in the event that the Contractor identifies an excluded individual with an ownership or control interest.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

2.18.07 Disclosures Made by Providers to the Contractor

In accordance with 42 CFR 1002.3^{xlv} and 42 CFR 1001.1001, before the Contractor enters into or renews a provider agreement, or at any time upon written request by EOHHS, the Contractor will disclose to EOHHS in writing the identity of any person who:

- (A) Has been convicted of a criminal offense as described in Sections 1128(a) and 1182(b) (1), (2), or (3) of the Social Security Act
- (B) Has had civil money penalties or assessments imposed under Section 1129A of the Social Security Act; or
- (C) Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:
 - (1) A direct or indirect ownership interest of five (5) percent or more in the entity;
 - (2) Is the owner of a whole or part interest in any mortgage, deed of trust, note for other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceed five (5) percent of the total property and assets of the entity;
 - (3) Is an officer or director of the entity, if the entity is organized as a corporation;
 - (4) Is partner in the entity, if the entity is organized as a partnership;
 - (5) Is an agent of the entity; or
 - (6) Is a managing employee, that is (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or was formerly described in paragraph (a)(1)(ii)(A)

of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in paragraph (a) (2) of this section, in anticipation of or following a conviction, assessment of a CMP, or imposition of an exclusion.

For the purposes of this section, the following terms (agent, immediate family member, indirect ownership interest, member of household, and ownership interest) will have the meaning specified in 42 CFR 1001.1001:

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a ten (10) percent ownership interest in an entity at issue if he or she has a twenty (20) percent ownership interest in a corporation that wholly owns a subsidiary that is a fifty (50) percent owner of the entity in issue.)

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Ownership interest means an interest in:

- (i) The capital, the stock, or the profits of the entity, or
- (ii) Any mortgage, deed, trust or note, or other obligation secured in whole or party by the property or assets of the entity.

The Contractor must notify EOHHS in writing within ten (10) business days of the receipt of any disclosures which have been made to the Contractor.

The Contractor must promptly notify EOHHS in writing within ten (10) business days of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Contractor's concern about Medicaid program integrity or quality. Provider credentialing requirements are addressed further in Section 2.12.05, Provider Credentialing.

The Contractor must also promptly notify EOHHS in writing within ten (10) business days of any action that it takes to limit the ability of an individual or entity to participate in its program,

regardless of what such an action is called, when this action is based on the Contractor's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program.

The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section.

2.18.08 Compliance with all Rhode Island Regulations

The Contractor agrees to comply with all applicable RI State laws and regulations including but not limited to:

1. Effective 1/1/2017, R.I. Gen. Laws § 27-18-50.1, R.I. Gen. Laws § 27-19-26.1, R.I. Gen. Laws § 27-20-23.1, and R.I. Gen. Laws § 27-41-38.1, Medication Synchronization
2. Effective 1/1/2017, R.I. Gen. Laws § 27-55-1 and R.I. Gen. Laws 27-55-2, Off-Label Uses for Prescription Drugs
3. Effective 1/1/2018, R.I. Gen. Laws § 27-18.9-8, External Appeals Procedural Requirements
4. Effective 1/1/19, Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies, SECTION 9, Chapter 40-8.4-20 "Health Care for Families", Continuous Coverage for Contraception.

2.18.09 Compliance with all Federal Regulations

The Contractor agrees to comply with all applicable Federal laws and regulations.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

3.01 GENERAL PROVISIONS

3.01.01 Contract Composition and Order of Precedence

Any submission made by the Contractor in response to the State's Letter of Intent (Bid Specifications) Document will be incorporated into this Agreement by reference. This Agreement will be in conformity with, and will be governed by, all applicable laws of the Federal government and the State of Rhode Island.

The component parts of the Agreement between the State of Rhode Island and the Contractor will, in addition to the foregoing, consist of ADDENDUM I-XIX and:

ATTACHMENT A: Schedule of In-Plan Benefits
ATTACHMENT B: Schedule of Out-of-Plan Benefits
ATTACHMENT C: Schedule of Non-Covered Services
ATTACHMENT D: Rhode Island EPSDT Periodicity Schedule
ATTACHMENT E: Rhode Island Nutrition Standards
ATTACHMENT F: Extended Family Planning Benefits
ATTACHMENT G: FQHC and RHC Services
ATTACHMENT I: Contractor's Locations
ATTACHMENT J: Contractor's Capitation Rates SFY 2016
ATTACHMENT K: Contractor's Insurance Certificates
ATTACHMENT L: Rate-Setting Process
ATTACHMENT N: Special Terms and Conditions
ATTACHMENT O: Mental Health, Substance Use and Developmental Disability Services for Children
ATTACHMENT P: Behavioral Health and Substance Use Services for Adults
ATTACHMENT Q: Care Management Protocols for Members
ATTACHMENT U: Claims Based Data Elements

3.01.02 Integration Clause

This Agreement will represent the entire agreement between the parties and will supersede all prior negotiations, representations, or agreements, either written or oral, between the parties relating to the subject matter hereof. This Agreement will be independent of, and have no effect upon, any other contracts of either party, except as set forth to the contrary within.

3.01.03 Subsequent Conditions

The Contractor will comply with all requirements of this Agreement and the State will have no obligation to enroll any recipients into the Health Plan until such time as all of said requirements have been met.

3.01.04 Effective Date and Term

All terms and conditions stated herein are subject to final approval from CMS. This Agreement will be effective from March 1, 2017 and will be signed by the Contractor and the Rhode Island Executive Office of Health and Human Services and approved by CMS. The contract for five (5) years under the terms herein for the period March 1, 2017 to June 30, 2022 with five (5) one-year option periods, unless terminated prior to that date by provisions of this Agreement or extended by mutual agreement of the parties as provided for in this contract.

EOHHS may, at its discretion, defer the contractual operational start date for up to two (2) months beyond the scheduled start date of March 1, 2017 for a Contractor that has been approved in the initial review process but that fails to satisfy all readiness review requirements.

3.01.05 Contract Administration

This Agreement will be administered for the State by the Rhode Island Executive Office of Health and Human Services (EOHHS). The Medicaid Director or their appointee will serve as the responsible party for all matters related to this Agreement.

The Administrator, or his or her designee, will be the Contractor's primary liaison in working with other State staff and with the State's private program management contractor. In no instance will the Contractor refer any matter to Medicaid Director or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the Administrator or designee.

Whenever the State is required by the terms of this Agreement to provide written notice to the Contractor, such notice will be signed by the EOHHS Administrator or designee, or, in that individual's absence or inability to act, such notice will be signed by Medicaid Director. All notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in this Article will be issued by the EOHHS Administrator or designee.

3.01.06 Contract Officers

EOHHS will designate a Contract Officer. Such designation may be changed during the period

of this Agreement only by written notice. The Contractor's Chief Executive Officer will be authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of this Agreement.

3.01.07 Liaisons

The Contractor will designate an employee of its administrative staff and EOHHS hereby designates its Contract Officer, who will act as liaisons, between the Contractor and EOHHS for the duration of the Agreement. The Contract Officer will receive all inquiries regarding this Agreement and all required reports. The Contractor also will designate a member of its senior management who will act as a liaison between the Contractor's senior management and EOHHS when such communication is required.

3.01.08 Notification of Administrative Changes

The Contractor will notify EOHHS of all changes materially affecting the delivery of care or the administration of its program. An example of such a material change would be a change which could affect the Contractor's ability to meet performance standards.

3.01.09 Notices

Any notice under this Agreement required to be given by one party to the other party, will be in writing and given by certified mail, return receipt requested postage pre-paid or overnight carrier which requires a receipt, of delivery in hand with a signed for receipt, and will be deemed given upon receipt.

Notices will be addressed as follows:

In case of notice to the Contractor: Chief Executive Officer

In case of notice to EOHHS: EOHHS Administrator, 3 West Road, Virks Building, Cranston, RI 02920

Either party may change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

3.01.10 Authority

Each party has full power and authority to enter into and perform this Agreement, except to the extent noted in Section 3.01.11, Federal Approval of Contract below, and by signing this Agreement, each party certifies that the person signing on its behalf has been properly authorized and empowered to enter into this Agreement. Each party further acknowledges that it has read

this contract, understands it, and agrees to be bound by it.

3.01.11 Federal Approval of Contract

Under 42 CFR 438.6ⁱⁱⁱ, CMS has final authority to approve all comprehensive risk contracts between states and contractors in which payment exceeds one-hundred thousand dollars (\$100,000.00). If CMS does not approve a contract entered into under the Terms & Conditions described herein, the Agreement will be considered null and void.

3.01.12 Special Terms and Conditions

The Contractors will comply with the requirements specified in ATTACHMENT N of this Agreement.

3.02 INTERPRETATIONS AND DISPUTES

3.02.01 Conformance with State and Federal Regulations

The Contractor agrees to comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including those not specifically mentioned in this Article. In the event that the Contractor may, from time to time, request the State to make policy determinations or to issue operating guidelines required for proper performance of this Agreement, the State will do so in a timely manner, and the Contractor will be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and will incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

On May 6, 2016, following an extended period of review and public comment on proposed rules, CMS issued its final rule governing Medicaid managed care programs. (Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability). The final rule, as presented, is intended to modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery system. The Contractor is required to meet all regulations specified in 42 CFR 438.

3.02.02 Waivers

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement will be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such

forbearance or indulgence, the other party will have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings.

Waiver of any breach of any term or condition in this Agreement will not be deemed a waiver of any prior or subsequent breach. No term or condition of this Agreement will be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

3.02.03 Severability

If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and the Contractor will be relieved of all obligations arising under such provision; if the remainder of this Agreement is capable of performance, it will not be affected by such declaration or finding and will be fully performed. To this end, the terms and conditions defined in this Agreement can be declared severable.

3.02.04 Jurisdiction

This Agreement will be governed in all respects by the Laws and Regulation of the State of Rhode Island. The Contractor agrees to submit to the jurisdiction of the State of Rhode Island should any dispute, disagreement or any controversy of any kind arise or result out of the terms, conditions or interpretation of this Agreement. The Contractor, by signing this Agreement, agrees and submits to the jurisdiction of the courts of the State of Rhode Island and agrees that venue for any legal proceeding against the State regarding this Agreement will be filed in the Superior Court of Providence County.

3.02.05 Disputes

Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Chief Purchasing Officer of the State of Rhode Island is authorized, subject to any limitations or conditions imposed by regulations, to settle, compromise, pay, or otherwise adjust the dispute by or against or in controversy with, a Contractor relating to a contract entered into by the Department of Administration on behalf of the State or any State agency, including a claim or controversy based on contract, mistake, misrepresentation, or other cause for contract modification or rescission, but excluding any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official other than the Chief Purchasing Officer is specifically authorized to settle or determine such controversy.

A “contract dispute” will mean a circumstance whereby a Contractor and the State user agency are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of a contract.

The Chief Purchasing Officer will be authorized to resolve contract disputes between the

Contractors and user agencies upon the submission of a request in writing from either party, which request will provide:

- A description of the problem, including all appropriate citations and references from the contract in question.
- A clear statement by the party requesting the decision of the Chief Purchasing Officer's interpretation of the contract.
- A proposed course of action to resolve the dispute.

The Chief Purchasing Officer will determine whether:

- The interpretation provided is appropriate.
- The proposed solution is feasible.
- Another solution may be negotiable.

If a dispute or controversy is not resolved by mutual agreement, the Chief Purchasing Officer or his designee will promptly issue a decision in writing after receipt of a request for dispute resolution. A copy of the decision will be mailed or otherwise furnished to the Contractor. If the Chief Purchasing Officer does not issue a written decision within thirty (30) days after written request for a final decision, or within such longer period as might be established by the parties to the contract in writing, then the Contractor may proceed as if an adverse decision had been received.

In the event an adverse decision is rendered, the Contractor may proceed to Superior Court and commence litigation against the State in accordance with Section 3.02.04 (Jurisdiction). If damages awarded on any contract claim under this section exceed the original amount of the contract, such excess will be limited to an amount which is equal to the amount of the original contract. No person, firm, or corporation will be permitted more than one (1) money recovery upon a claim for the enforcement of or for breach of contract with the State.

In no event, will the terms of this section apply to disputes between providers and the Contractor nor will the State be entitled to arbitrate such disputes.

Any fraudulent activity may result in criminal prosecution.

3.03 CONTRACT AMENDMENTS

3.03.01 General

The Executive Office may permit changes in the scope of services, time of performance, or

approved budget of the Contractor to be performed hereunder. Such changes, which are mutually agreed upon by the Executive Office and the Contractor, must be in writing and will be made a part of this agreement by numerically consecutive amendment excluding "Special Projects", if applicable, and are incorporated by reference into this Agreement.

Special Projects are defined as additional services available to the Executive Office on a time and materials basis with the amounts not to exceed the amounts referenced on the Contractor's RFP cost proposal or as negotiated by project or activity. The change order will specify the scope of the change and the expected completion date. Any change order will be subject to the same terms and conditions of this Agreement unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the length of this Agreement. Formal contract amendments will be negotiated by the State with the Contractor whenever necessary to address changes to the terms and conditions, the costs of, or the scope of work included under this Agreement. An approved contract amendment means one approved by EOHHS, the Contractor, and all other applicable State and Federal agencies prior to the effective date of such change.

An approved contract amendment will be in writing and will be signed by EOHHS, the Contractor and all other applicable State and Federal agencies prior to the effective date of the Amendment.

The Contractor agrees to provide a signed amendment no later than forty-five (45) calendar days after being provided the final Amendment by EOHHS. Failure to return a signed Amendment within forty-five (45) calendar days or to negotiate a new due date with EOHHS may result in, but not be limited to, a hold placed on the approval of member materials or suspension of auto-enrollment of members, to be in place until return of an executed copy of the Amendment.

The State and the Contractor will use contract amendments to reduce or increase Capitation Payments caused either through changes in the scope of benefits as a result of changes in Federal or State law or regulations or any other reason, scope of benefits otherwise covered by the State, the beneficiaries covered by this Agreement, and/or extension of the term of this Agreement. Annual adjustments in capitation payments will be made in conformance with actuarial soundness provisions found in 42 CFR 438.6(c)^{xlvi} for actuarial soundness, for any applicable period of time, taking into account the budget neutrality limitations placed on Rhode Island Medicaid by CMS.

3.04 PAYMENT

3.04.01 Capitation Payments

The Contractor will receive Capitation Payments in the manner described in Section 2.15

(Payment To and From Plans) of this Agreement. All payments will be subject to the availability of funds. Adjustments to Capitation Payments due to member reconciliations will be made in the month following their discovery.

3.04.02 Fee-For-Service Payments

The State will reimburse the Contractor on a fee-for-service basis for covered services billed by the Contractor and not included within the pre-paid benefit package as described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement. The State will reimburse the Health Plan in the same manner it reimburses other fee-for-service providers.

3.04.03 Payments to Subcontractors and Providers

The State will bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Health Plan subcontractors, including providers and suppliers (see also Section 3.05.05, *Subcontracts*).

3.04.04 Liability for Payment

The Contractor agrees that members are not held liable as follows:

- The Contractor's debts, in the event of the Contractor's insolvency
- Covered services provided to the member, for which the State does not pay the Contractor, or the State, or the Contractor, does not pay the individual or the health care provider that furnishes the services under a contractual, referral, or other arrangement, or
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly

3.04.05 Payments for Health System Transformation Project Incentives

EOHHS will make HSTP related payments to the Contractor as described in Section 2.08.02. All payments will be subject to the availability of funds.

3.04.06 Payments for Federal Qualified Health Centers (FQHCs) and Rural health Centers (RHCs)

If the Contractor includes FQHCs or RHCs in its provider network, Contractor is required to address cost issues related to the scope of services rendered by these providers and must reimburse FQHCs/RHCs either on a capitated (risk) basis considering adverse selection factors or on a cost related basis. The Contractor is required to reimburse FQHCs/RHCs at a rate not less than that paid for comparable services provided by non-FQHC/RHC based providers. The Contractor is required to ensure that the total revenue it provides to each FQHC/RHC is equal to the number of eligible encounters as outlined in EOHHS' "Principles of Reimbursement for Federally Qualified Health Centers" multiplied by that FQHCs/RHCs rate for the fiscal year, as shared by EOHHS. This funding is provided for in the rates.

3.05 GUARANTEES, WARRANTIES, AND CERTIFICATIONS

3.05.01 Contractor Certification of Truthfulness

By signing this Agreement, the Contractor certifies, under penalty of law, that the information provided herein is true, correct, and complete to the best of the Contractor's knowledge and belief. The Contractor acknowledges that should investigation at any time disclose any misrepresentation or falsification, this Agreement may be terminated by EOHHS upon written notice specifying the misrepresentation or falsification without penalty of further obligation by EOHHS.

3.05.02 Contractor Certification of Legality

The Contractor represents, to the best of its knowledge, that it has complied with and is complying with all applicable statutes, orders, and regulation promulgated by any Federal, State, municipal, or other governmental authority relating to its property and the conduct of operations; and, to the best of its knowledge, there are no violations of any statute, order, rule, or regulation existing or threatened.

3.05.03 Contractor Certification of HMO Licensure

The Contractor certifies that it meets all the requirements for a State-defined HMO as specified in the laws of Rhode Island and the rules of the Rhode Island Department of Business Regulation. If, at any time during the term of this Agreement, the Contractor incurs loss of State approval and/or qualification as an HMO, such loss will be reported to EOHHS. Such loss may be grounds for termination of the Agreement under the provisions of Section 3.10 (Termination of the Contract).

If the Contractor is not a State-licensed HMO, the Contractor certifies that it meets the other requirements specified in Section 2.02 (Licensure, Accreditation, and Certification) of this Agreement. If the Contractor is not a State-licensed HMO and, at any time during the term of

this Agreement, fails to meet the other requirements set forth in Section 2.02 (Licensure, Accreditation, and Certification) of this Agreement, such failure will be reported to EOHHS. Such failure may be grounds for termination of this Agreement under the provisions of Section 3.10.

3.05.04 Performance Bond or Substitutes

The Contractor will furnish a performance bond, a cash deposit, or an irrevocable letter of credit. The performance bond will be in a form acceptable to the State. If a cash deposit is used, it should be placed in different financial institutions to a maximum of one-hundred thousand dollars (\$100,000.00) per deposit. If a letter of credit is used, the letter should be issued by a bank doing business in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation; a savings and loan institution doing business in the State of Rhode Island and insured by the Federal Savings and Loan Insurance Corporation; or a credit union doing business in the State of Rhode Island and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit, or letter of credit will be a minimum of one dollar for each capitation dollar paid in the month, or as determined by the EOHHS Administrator or designee. The total capitation amount will include projected SOBRA payments. The State will evaluate the enrollment statistics of the Contractor on a monthly basis. If there is an increase in the total capitation payment that exceeds 10 percent (10) above the previous month's total Capitation Payment, the State may require a commensurate increase in the amount of the performance bond, cash deposit, or letter of credit. The Contractor will have ten (10) business days to comply with any such increase.

The State may, at its discretion, permit the Contractor to offer substitute security in lieu of a performance, bond, cash deposit, or letter of credit. In that event, the Contractor will be solely responsible for establishing the credit worthiness of all forms of substitute security. The Contractor also will agree that the State may, after supplying written notice, withdraw its permission for substitute security, in which case the Contractor will provide the State with a form of security as described above. In the event of termination for default, the performance bond, cash deposit, letter of credit or substitute will become payable to the State for any outstanding damage assessments against the Contractor. Up to the full amount of the performance bond or substitute may also be applied to the Contractor's liability for any administrative costs and/or excess medical or other costs incurred by EOHHS in obtaining similar services to replace those terminated as a result of the default. The State may seek other remedies under law or equity in addition to this stated liability.

3.05.05 Subcontracts and Delegation of Duty

All subcontracts must be in writing and fulfill the requirements of 42 CFR 438.230^{xlvi} that are appropriate to the service or activity delegated under this Agreement. The Contractor will make available all subcontracts for inspection by the State, upon request. The Contractor may enter into written subcontract(s) for performance of certain contract responsibilities listed in

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS of this Agreement. The Contractor must evaluate any prospective subcontractor's readiness and ability to perform the delegated contract responsibilities prior to assigning the activities by way of a detailed pre-delegation audit. The audit will encompass all duties and responsibilities that have been delegated to the subcontractor and will be evaluated for risk. The progress of the audit will be reported in a format and frequency specified by EOHHS. The audit must be completed and the results provided to EOHHS no less than thirty (30) business days prior to the scheduled "Go Live" date.

The HIPAA Privacy Rule requires that a covered entity obtain satisfactory assurances from its subcontracted and delegated entities that they will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other business associate agreement between the covered entity and the business associate.

The Contractor will monitor the performance of all subcontractors on an ongoing basis. This includes conducting formal reviews based on a schedule established by EOHHS and which is consistent with industry standards and State regulations. Both the Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.

The Contractor will be wholly responsible for performance of the entire contract whether or not subcontractors are used. In compliance with 42 CFR.438.230(b)(2)(ii), the Contractor must execute a written agreement with its subcontractors that specifies that Contractor's right to revoke the subcontract, and outlines reasons for the revocation of the contract, or specify other remedies in instances where the State or the Contractor determines that the subcontractor has not performed satisfactorily. The Contractor must also execute a written agreement which states that the Contractor may impose sanction on the subcontractor if the subcontractor's performance is inadequate. The Contractor must also execute a written agreement with their subcontractors which states that the subcontractor agrees that the State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General, or their authorized representatives, may audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State for ten (10) years from the final date of the contract period or from the date of the completion of any audit, whichever is later. If The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General, or their authorized representatives determine that there is a reasonable possibility of fraud, they may inspect, evaluate, and audit the subcontractors at any time. Any subcontract which the Contractor enters into with respect to performance under this Agreement will not relieve the Contractor in any way of responsibility for performance of its duties. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement

(see also Section 3.05.06, *Assignment of the Contract*).

The Contractor will give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the Contractor or subcontractor that, in the opinion of the Contractor, may result in litigation related in any way to the Agreement with EOHHS.

Executive Order 92-4 encourages each State agency to meet a goal of ten percent (10%) of the dollar value of all procurement be awarded to small and small disadvantaged and minority and woman-owned businesses as subcontractors, pursuant to the provisions of Part 19 of Title 48, Federal Acquisition Regulations; 45 CFR 74.44, ATTACHMENT J: Capitation Rates; and Chapter 37-2.5.5.2.

The Contractor agrees, and will require its Subcontractors to agree, to subrogate to EOHHS any and all claims the Contractor has or may have against any provider, including but not limited to manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products, in actions brought against said Providers, etc., on behalf of EOHHS, through the Rhode Island Attorney General's Office. The Contractor is entitled to recoveries that are the direct result of a similar legal suit filed by the Contractor against the same party or parties that was initiated and properly filed prior to the date of a legal action initiated or joined by EOHHS or by Rhode Island Department of Attorney General.

In compliance with 42 CFR 438.414 and 42 CFR 438.10(g)(1), the Contractor agrees to inform providers and subcontractors, at the time they enter into a contract, about:

1. Enrollee's right to a state fair hearing,
2. How an enrollee can obtain a hearing,
3. Representation rules at a hearing
4. Right to file a grievance and appeal and,
5. The requirements and timeframe for filing a grievance and appeal
6. Right to request continuation of benefits during an appeal or State Fair Hearing filing but that the enrollee may be responsible for the cost of any continued benefit if the original action is upheld.
7. The toll-free number to file oral grievances and appeals.
8. State-determined provider's appeals rights to challenge the failure of an organization to cover a service.

All of the program standards described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS will apply to sub-contractors, to the extent relevant, to the duties they are performing. In addition, the provisions of the following ARTICLE III: CONTRACT TERMS AND CONDITIONS clauses will apply to subcontractors:

Subsection 3.01.11	Federal Approval of Contract
Subsection 3.02.01	Conformance with State and Federal Regulations
Subsection 3.02.03	Severability
Subsection 3.05.07	Hold Harmless

Subsection 3.05.08	Insurance
Subsection 3.05.10	Patent or Copyright Infringement
Subsection 3.06.01	Employment Practices
Subsection 3.06.03	Independent Capacity of Contractor Personnel
Subsection 3.07.03	Fraud and Abuse
Subsection 3.08	Inspection of Work Performed
Subsection 3.09	Confidentiality of Information
Subsection 3.11.02	Ownership of Data and Reports

All requirements of this Section apply to subcontracts with Accountable-Entities. Additionally, subcontracts with AEs may not include delegation of network contracting, provider payment and/or claims processing, member services. The Contractor must ensure that the entities are in compliance with all member beneficiary protections, including notices, and appeal rights. The Contractor will have a written plan for monitoring and oversight of performance under these subcontracts, including provisions for assessing subcontract compliance and corrective actions and/or termination as appropriate. Such oversight will include ensuring compliance with all requirements pertaining to marketing, member communications, and member choice. All risk-based subcontracts with Accountable Entities must ensure compliance with State and Federal regulations and must be approved by EOHHS.

3.05.06 Assignment of the Contract

The Contractor will not sell, transfer, assign, or otherwise dispose of this Agreement or any portion thereof or of any right, title, or interest therein without the prior written consent of the State. Such consent, if granted, will not relieve the Contractor of its responsibilities under this Agreement. This provision includes reassignment of this Agreement due to change in ownership of the firm. State consent will not be unreasonably withheld.

3.05.07 Hold Harmless

The Contractor will indemnify and hold the State of Rhode Island, its Executive Offices, agencies, branches and its or their officers, directors, agents or employees (together the "Indemnities" and their subcontractors) harmless against from:

- Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract.
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by the Contractor, its officers, employees, or subcontractors in the performance of the contract.

- Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the contract in a manner not authorized by the contract or by Federal or State regulations or statutes.
- Any failure of the Contractor, its officers, employees, or subcontractors to observe the Federal or State laws, including, but not limited to, labor laws and minimum wage laws.
- Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

Before delivering services under this Agreement, the Contractor will provide adequate demonstration to the State that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 3.05.08, Insurance.

The Contractor may elect to self-insure any portion of the risk assumed under the provision of this Agreement based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse financial actions, including withholding of payment or imposition of damages by the State.

3.05.08 Insurance

Before delivering services under this Agreement, the Contractor will obtain, from an insurance company duly authorized to do business in Rhode Island, the minimum coverage levels described below for:

- Professional liability insurance
- Workers' compensation
- Comprehensive liability insurance
- Property damage insurance
- Errors and Omissions insurance
- Reinsurance

ATTACHMENT K of this Agreement contains the Contractor's Certificates of Insurance. Each certificate states the policy, the insured, and the insurance period. Each of the Contractor's insurance policies will contain a clause, which requires the State be notified ten (10) days prior to cancellation.

The Contractor will be in compliance with all applicable insurance laws of the State of Rhode Island and of the Federal Government throughout the duration of this Agreement.

3.05.08.01 Professional Liability Insurance

The Contractor will obtain and maintain, for the duration of this Agreement, professional liability insurance in the amount of at least one-million dollars (\$1,000,000.00) for each occurrence.

3.05.08.02 Workers' Compensation

The Contractor will obtain and maintain, for the duration of this Agreement, workers' compensation insurance for all of its employees employed in Rhode Island. In the event any work is subcontracted, the Contractor will require the subcontractor similarly to provide workers' compensation insurance for all the latter's employees employed at any site in Rhode Island, unless such subcontractor's employees are covered by the workers' compensation protection afforded by the Contractor. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State of Rhode Island.

3.05.08.03 Minimum Liability and Property Damage Insurance

The Contractor will obtain, pay for, and keep in force general liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of one-million dollars (\$1,000,000.00) for any one (1) occurrence; and insurance against liability for property damages, as well as first-party fire insurance, including contents coverage for all records maintained pursuant to this Agreement, in the amount of five-hundred thousand dollars (\$500,000.00) for each occurrence; and such insurance coverage that will protect the State against liability from other types of damages, for up to five-hundred thousand dollars (\$500,000.00) for each occurrence.

3.05.08.04 Errors and Omissions Insurance

The Contractor will obtain, pay for, and keep in force for the duration of the contract Errors and Omissions insurance in the amount of one-million dollars (\$1,000,000.00).

3.05.08.05 Reinsurance

The Contractor will obtain, pay for, and keep in force reinsurance for the reimbursement of excess costs incurred by a member. The level at which the Contractor establishes reinsurance must be consistent with sound business practices under the financial condition of the Contractor. The Contractor may not change the thresholds from those submitted in response to the bid solicitation and incorporated into ATTACHMENT K of this Agreement without the prior written consent of the State.

3.05.08.06 Evidence of Coverage

The Contractor will furnish to the State upon request a certificate(s) evidencing that required insurance is in effect, for what amounts, and applicable policy numbers and expiration dates prior to start of work under the Agreement. In the event of cancellation of any insurance coverage, the Contractor will immediately notify the State of such cancellation. The Contractor will provide the State with written notice at least ten (10) days prior to any change in the insurance required under this subsection.

The Contractor will also require that each of its subcontractors maintain insurance coverage as specified above or provide coverage for each subcontractor's liability and employees. The provisions of this clause will not be deemed to limit the liability or responsibility of the Contractor or any of its subcontractors hereunder.

3.05.09 Force Majeure

Neither the Contractor nor the State will be liable for any damages or excess costs for failure to perform their contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by the Contractor or the State. Such causes may include, but are not restricted to, fires, earthquakes, tornadoes, floods, unusually severe weather, or other catastrophic natural events or acts of God; quarantine restrictions; explosions; subsequent legislation by the State of Rhode Island or the Federal government; strikes other than the Contractor's employees; and freight embargoes. In all cases, the failure to perform must be beyond reasonable control of, and without fault or negligence of, either party.

3.05.10 Patent or Copyright Infringement

The Contractor will represent that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from the Contractor's use of any equipment, materials, computer software and products, or information prepared by or on behalf of the Contractor, or developed in connection with the Contractor's performance of this Agreement, then the Contractor will, at its expense, defend such claim or suit. The Contractor will satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with the Contractor's right of approval.

3.05.11 Clinical Laboratory Improvement Amendments (CLIA) Of 1988

All laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the tests permitted under the terms of their CLIA waiver from CMS'

Division of Laboratory Services. Laboratories with certificates of registration may perform a full range of laboratory tests. The Contractor will require all subcontractors and participating providers to conform to this requirement.

3.05.12 Sterilization, Hysterectomy, and Abortion Procedures

The Contractor will follow Rhode Island Medicaid policy and consent procedures on sterilizations, hysterectomy, and abortion services for members. Members may self-refer to in-network providers for allowable abortion services.

3.05.13 Payments to Institutions or Entities Located Outside of the U.S.

In compliance with 42 CFR 438.602(i), the Contractor must be located within the U.S. The Contractor will make no payments to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. The Contractor will issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. The Contractor is prohibited from making payments to telemedicine providers and pharmacies located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

3.06 PERSONNEL

3.06.01 Employment Practices

The Contractor will agree to comply with the requirements relating to fair employment practices, to the extent applicable and agrees further to include a similar provision in any and all subcontracts. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap. The Contractor will take affirmative action to ensure that employees, as well as applicants for employment, are treated without regard to their race, color, religion, sex, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Such action will be taken in areas including, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

The Contractor will agree to post in a conspicuous place, available to employees and applicants for employment, notices setting forth the provision of this non-discrimination clause. The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, age (except as provided by

law), marital status, political affiliation, or handicap, except where it relates to bona fide occupational qualification. The Contractor will send to each labor union or representative of workers with which he has a collective bargaining arrangement or other agreement or understanding, a notice advising the labor union or workers' representative of the Contractor's commitments under Section 202 of Executive Order No. 11246 of September 24, 1976, as amended, and the rules, regulations, and relevant orders of the Secretary of Labor.

The Contractor will agree to comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 USC 2000D et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794); Title IX of the Education Amendments of 1972 (20 USC 1681 et seq.); Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.); The Food Stamp Act, and the Age Discrimination Act of 1975; the United States Department of Health and Human Services regulations found in 45 CFR, parts 80 and 84; the United States Department of Education implementing regulations (34 CFR, parts 104 and 106) which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities; and the United States Department of Agriculture, Food and Nutrition Services (7 CFR 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, political beliefs, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities, or as any of the Acts are amended from time to time.

The Contractor will comply with all provisions of Executive Order No. 11246 of September 24, 1976, as amended, and of the rules, regulations, and relevant orders of the Secretary of Labor. The Contractor will furnish all information and reports required by Executive Order No. 11246 of September 24, 1976, as amended, and by the rules, regulations, and orders of the Secretary of Labor or pursuant thereto and will permit access to its books, records, and accounts by the Secretary of the U.S. Department of Health and Human Services and the U.S. Secretary of Labor or their authorized representatives for purposes of investigation to ascertain compliance with rules, regulations, and orders.

The Contractor will comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Orders 11625 and 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor will comply with regulations issued by the Secretary of Labor of the United States in Title 20, Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758 and the Federal Rehabilitation Act of 1973. The Contractor will be responsible for ensuring that all subcontractors comply with the above-mentioned regulations. The Contractor and its subcontractors will comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Vocational Rehabilitation Act of 1973, as amended.

The Contractor will comply with all applicable provisions of Stat. 53-1147, the Federal "Hatch Act," as amended.

The Contractor will comply with all applicable provisions of Public Law 101-336, Americans with Disabilities Act.

Pursuant to Title VI and Section 504, as listed above and as referenced in ADDENDUM II and ADDENDUM III, which are incorporated herein by reference and made part of this Agreement, the Contractor will have policies and procedures in effect, including, mandatory written compliance plans, which are designed to assure compliance with Title VI section 504, as referenced above. An electronic copy of the Contractor's written compliance plan, all relevant policies, procedures, workflows, relevant chart of responsible personnel, and/or self-assessments must be available to EOHHS upon request.

The Contractor's written compliance plans and/or self-assessments, referenced above and detailed in ADDENDUM II and ADDENDUM III of this Agreement must include but are not limited to the requirements detailed in ADDENDUM II and ADDENDUM III of this Agreement.

The Contractor must submit, within thirty-five (35) days of the date of a request by DHHS or EOHHS, full and complete information on Title VI and/or Section 504 compliance and/or self-assessments, as referenced above, by the Contractor and/or any subcontractor or vendor of the Contractor.

The Contractor acknowledges receipt of ADDENDUM II - Notice to executive office of health and human services' service providers of their responsibilities under TITLE VI of the civil rights act of 1964 and ADDENDUM VI - Notice to executive office of health and human services' service providers of their responsibilities under section 504 of the Rehabilitation Act of 1973, which are incorporated herein by reference and made part of this Agreement.

The Contractor further agrees to comply with all other provisions applicable to law, including the Americans with Disabilities Act of 1990; the Governor's Executive Order No. 05-01, Promotion of Equal Opportunity and the Prevention of Sexual Harassment in State Government.

The Contractor also agrees to comply with the requirements of the Executive Office of Health and Human Services for safeguarding of client information as such requirements are made known to the Contractor at the time of this contract. Changes to any of the requirements contained herein will constitute a change and be handled in accordance with the Contract Amendments noted in Section 3.03.

Failure to comply with this Paragraph may be the basis for cancellation of this Agreement.

The Contractor will agree to comply with all other State and Federal statutes and regulations that are or may be applicable and that are not specifically mentioned above.

3.06.02 Employment of State Personnel

The Contractor will not knowingly engage on a full-time, part-time, or other basis, during the period of this Agreement, any professional or technical personnel who are, or have been at any

time during the period of this Agreement, State employees, except those regularly retired individuals, without prior written approval from the EOHHS Administrator or designee. Such approval will not be unreasonably withheld.

The penalty for violation of the above conditions will result in a two thousand, five hundred dollars (\$2,500.00) penalty per employee, plus an added two thousand five hundred (\$2,500.00) penalty per month, per employee if the Contractor or subcontractor fails to terminate the employee after they have been notified in writing of the violation by the State's designated contract administrator.

3.06.03 Independent Capacity of Contractor Personnel

It is expressly agreed that the Contractor or any subcontractor involved in the performance of this Agreement will act in an independent capacity and not as an agent, officer, employee, partner, or associate of the State of Rhode Island. The Contractor staff will not hold themselves out as nor claim to be officers or employees of the State of Rhode Island by reason hereto. It is further expressly agreed that this Agreement will not be construed as a partnership or joint venture between the Contractor or any subcontractor and the State.

3.07 PERFORMANCE STANDARDS AND DAMAGES

3.07.01 Performance Standards for Medicaid Managed Care

The performance standards for Health Plans will be defined as substantial compliance with the program requirements specified in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS and the Attachments of this Contract. The Contractor agrees to cooperate fully with the State in its efforts to monitor and assess compliance with these performance standards. The Contractor will cooperate fully with the State or its designees in efforts to validate performance measures.

Failure to comply with the provisions of this section may subject the Contractor to intermediate sanctions including: (1) civil monetary penalties, as described in Section 3.07.04; (2) appointment of temporary management of the Health Plan, as provided for in 42 CFR 438.706^{xlvi}; (3) granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll; (4) suspension of new enrollment including automatic assignment after the effective date of the sanction; and/or (5) suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

3.07.02 Suspension of New Enrollment

Whenever the State determines that the Contractor, any of its delegated entities or subcontractors are in material breach of the performance standards described in Section 3.07.01, it may suspend

the Contractor's right to enroll new members. The State, when exercising this option, will notify the Contractor in writing of its intent to suspend new enrollment. The suspension period may be for a reasonable length of time specified by the State, depending on the severity and circumstances of the breach. The State also may notify enrollees of the Contractor non-performance and permit these enrollees to transition to another Health Plan.

3.07.03 Fraud and Abuse

3.07.03.01 General Requirements

The Contractor will establish and maintain internal controls which are designed and executed to prevent, detect, investigate, and report suspected Medicaid Fraud and Abuse that may be committed by network providers, non-network providers, vendors, subcontractors, employees, members, or other third parties with whom the Contractor contracts. The Contractor will comply with all Federal and State requirements regarding Medicaid fraud and abuse, including but not limited to Sections 1124, 1126(b)(1), 1126(b)(2), 1126(b)(3), 1128, 1156, 1892, 1902(a)(68), and 1903(i)(2) of the Social Security Act and Section 40-8.2- 2 of the General Laws of Rhode Island. EOHHS and its Office of Program Integrity may conduct audits at any time on the Contractor's formal fraud, waste and abuse program as well as any files as a result of claims audits.

The Contractor will cooperate fully with any investigations, including providing information, access to records, and access to interview the Contractor employees and consultants at the time determined by the State. Provider contracts with the Contractor will incorporate these terms and conditions.

The following terms (abuse, conviction or convicted, exclusion, fraud, furnished, practitioner, and suspension) will have the meaning specified in 42 CFR 455.2:

- Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- Conviction or convicted means that a judgment of conviction has been entered by a Federal, State, or local court; regardless of whether an appeal from that judgment is pending.
- Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
- Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or

some other person. It includes any act that constitutes fraud under applicable Federal or State law.

- **Furnished** refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)
- **Practitioner** means a physician or other individual licensed under State law to practice his or her profession.
- **Suspension** means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

An electronic copy of the Contractor's written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse must be submitted to the Rhode Island EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter.

3.07.03.02 Mandatory Components of Employee Education about False Claims Recovery

In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Contractor receives more than five million dollars (\$5,000,000) in Medicaid payments on an annual basis, then it must establish and disseminate written policies for all employees, including management and any subcontractor or agent of the Contractor, that include detailed information about the False Claims Act, established under sections 3279 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act).

Section 6032 of the Deficit Reduction Act establishes section 1902(a)(68) of the Social Security Act, which relates to "Employee Education about False Claims Recovery". The Contractor's written policies pertaining to employee education about false claims recovery may be on paper or in electronic form but must be readily available to all of the Contractor's employees, contractors, or agents. The Contractor's policies and procedures must include detailed information about the prevention and detection of Medicaid waste, fraud, and abuse.

The Contractor will also include in any employee handbook a specific discussion of the laws described in the written policies and the rights of employees to be protected as whistleblowers. The employee handbook must also include a specific discussion of the Contractor's policies and

procedures for preventing and detecting fraud, waste, and abuse.

3.07.03.03 Member Education about Medicaid Fraud and Abuse

The Contractor will educate its members about Medicaid fraud and abuse by including this subject matter in the contractor's member handbook. This content will address examples of possible Medicaid fraud and abuse by providers or vendors, as well by enrollees, and must be pre-approved by EOHHS.

In its member handbook, the Contractor will also inform enrollees about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free telephone number established by the Contractor for reporting possible Medicaid fraud and abuse, as well as information about how to contact EOHHS's Fraud Unit.

These member handbook requirements are addressed further in Section Required Information (Required Information).

3.07.03.04 Recipient Verification Procedures

In accordance with 42 CFR 455.20, the Contractor will be responsible for establishing procedures to verify with enrollees whether services billed by providers and vendors. Recipient verification requirements specific to workflows for the generation and dissemination of explanation of member benefits (EOMB) are addressed further in Section 3.07.03.05 (Explanation of Member Benefits).

The Contractor will document its recipient verification procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter. These recipient verification procedures may include but not be limited to the following:

- Informing enrollees in writing when goods or services have been prior authorized by the Contractor
- Notifying enrollees in writing when services which may require a concurrent authorization (such as a continued inpatient length of stay) have been approved by the Contractor
- Engaging in targeted outreach to enrollees whose pattern of health services utilization may warrant enrollment in any of the Contractor's care coordination or complex case management programs

Recipient verification procedures should delineate how the Contractor will respond to feedback from enrollees, including any interactions with recipients who report that goods or services

which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.07.03.06 (Investigating and Reporting Suspected Fraud and Abuse).

3.07.03.05 Explanation of Member Benefits

The Contractor will, in conformance with sampling requirements established by EOHHS, issue individual notices within forty-five (45) days of the payment of claims, to a sample of enrollees who received goods or services. The Contractor will omit from its sampling pool any claims that are associated with confidential services (as defined by the State).

These notices, or explanation of member benefits, must specify the following:

- The service furnished
- The name of the provider furnishing the service
- The date on which the service was furnished
- The amount of the payment made for the service

The Contractor will document its EOMB procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter. The EOMB procedures should delineate how the Contractor will respond to subsequent feedback from enrollees, including any interactions with recipients who report that goods or services which had been billed by a provider or vendor were not received. These procedures should address how such information from enrollees will be communicated to the Contractor's Fraud and Abuse Investigations Unit. The Contractor's processes for conducting investigations of possible fraudulent or abusive billing by providers or vendors are addressed further in Section 3.07.03.06 (Investigating and Reporting Suspected Fraud and Abuse).

3.07.03.06 Investigating and Reporting Suspected Fraud and Abuse

The Contractor will have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by 42 CFR 456.3, 456.4, and 456.23. The Contractor will initiate an investigation of possible Medicaid fraud and abuse based upon a variety of data sources, including but not limited to the following:

- Claims data mining to identify aberrant billing patterns

- Feedback from enrollees based upon EOMB transmittal processes
- Calls received on the Contractor's toll-free telephone number for reporting possible Medicaid fraud and abuse
- Peer profiling and provider credentialing functions
- Analyses of utilization management reports and prior authorization requests
- Monthly reviews of the CMS' List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM)
- Queries from State or Federal agencies

The Contractor is required to report any suspected cases of provider or vendor fraud and/or waste and abuse within five (5) business days, following the conclusion of its initial investigation, to the EOHHS Medicaid Contract Officer and/or designee as well as the Office of Program Integrity (PI). PI will review and process the referral and if there is a credible allegation of fraud, submit to the Rhode Island Attorney General MFCU and/or request additional evidence from the Health Plan.

The Contractor will have sufficient and dedicated staff in their Special Investigations Unit (SIU) and/or auditing unit. The Contractor will provide EOHHS and/or PI with the name and contact information of the designated individual within their SIU with whom the State or PI may:

- Communicate with directly; and
- Receive access to staff that are working to identify and resolve specific investigations, audits or cases of suspected fraud

The Office of Program Integrity (PI) may initiate meetings in addition to the quarterly Medicaid Fraud Control Unit meetings (MFCU) to engage in case discussions and to facilitate closure of outstanding investigations.

The Contractor, after reporting fraud or suspected fraud, will not take any of the following actions:

- Contact the subject; or
- Negotiate any settlement or agreement; or
- Accept any monetary or other thing of valuable in connection with the incident.

The Contractor will have a process for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. The Contractor will check with both the Office of Program Integrity, (OPI) and EOHHS before initiating any recoupment related to the outcome of a program integrity audit or prior to implementing any withhold of any funds for program integrity related issues.

While all recoveries related to overpayments due to fraud, waste or abuse, except of whistle blower cases, are retained by the Contractor, the Contractor will develop retention policies for the treatment of recoveries. The Contractor must provide an annual report of any monetary recoveries that result from reconciliation of cases of fraud.

In addition, the Contract will complete the State's updated reporting form and report quarterly run recoupments against the anticipated findings.

The Contractor will utilize EOHHS' quarterly MCO Program Integrity Report to report ongoing running totals of recoupments associated with individual cases as the mechanism by which to report the total recoupment for all cases within the calendar year.

3.07.03.06.01 Notifications and Tips

The Contractor will utilize the State provided template to make a referral in a secure, timely, and thoughtful manner as well as to alert both EOHHS and PI of a notification or "tip." In addition to reporting any suspected cases of provider or vendor fraud and/or abuse within five (5) business days following the close of an initial investigation, the Contractor will also submit quarterly reports to EOHHS documenting the Contractor's open and closed cases. Along with a notification, the Contractor will take steps to triage and/or substantiate these tips and provide timely updates when the concerns and/or allegations of any tips are authenticated.

The Contractor will notify the Office of Program Integrity in a timely manner regarding all incidents and/or concerns regarding the safety of its members.

The Contractor will cooperate fully in any investigation or prosecution. Such cooperation will include, but not be limited to, providing, upon request, information, access to records, and claims data.

3.07.03.06.02 Program Integrity Audits

The Office of Program Integrity reserves the right to conduct an annual on-site audit of the Contractor's fraud and abuse/SIU unit and program integrity activities.

3.07.04 Damages

The Contractor will use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties under this Agreement. The Contractor will be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement, up to a maximum cap of One Hundred Thousand Dollars (\$100,000); provided, however, that the Contractor agrees to indemnify and hold harmless EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs,

penalties, and expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of the Contractor or its employees, acting alone or in collusion with others; and provided, further, that this maximum cap on damages will not apply in the event that the loss arises in a situation in which the Contractor failed to follow its own policies and procedures.

The maximum civil monetary penalty levied will be in conformance with 42 CFR 438.704^{xlix}.

3.07.04.01 Non-Compliance with Program Standards

The Contractor will ensure that performance standards as described in Section 3.07.01 are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of this Agreement with respect to performance standards, unless otherwise specified below, damages will be assessed against the Contractor in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected members. When the non-compliance results in transfer of members to another Health Plan, the damages will include a maximum amount equal to the difference in the capitation rates paid to the Contractor and the rates paid to the replacement Health Plan. Damages will not be imposed until such time that the State has notified the Contractor in writing of a deficiency and has allowed a reasonable period of time for resolution.

3.07.04.02 Non-Compliance with Monthly Reconciliation Tasks

The Contractor will carry out the monthly member reconciliation tasks as described in ARTICLE II: HEALTH PLAN PROGRAM STANDARDS. The Contractor will be liable for the actual amount of any detected overpayments or duplicate payments identified as a result of State or Federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect Contractor action in conducting monthly member reconciliation.

3.07.04.03 Non-Compliance with Data Reporting Standards

Contractor shall comply with the operational and financial data reporting requirements described respectively in the document entitled *EOHHS Medicaid Managed Care Organization (MCO) Requirements for Reporting and Reporting Penalties* and Sections 2.13.01, 2.16.03, and 2.17.02 of this Agreement.. Included is any ad hoc reporting requested for the purpose of investigating fraud or abuse or to validate data in the State's data warehouse. In addition, all reports provided to EOHHS will be attested to individually by the Contractor. The Contractor may be assessed a financial penalty of up to two-thousand five-hundred dollars (\$2,500.00) for each occurrence in which the Contractor fails to submit a report timely, accurately, in the correct template and/or with the proper naming convention and does not remedy the error within three (3) business days of notification of the error from EOHHS.

3.07.04.04 Basis for Imposition of Intermediate Sanctions

EOHHS may impose intermediate sanctions on the Contractor as specified in 42 CFR 438.700^l and 42 CFR 438.702^{li} if it makes any of the determinations specified in paragraphs (a) through (c). The EOHHS may base its determinations on findings from onsite surveys, member or other complaints, financial status, or any other source.

- (a) EOHHS determines that the Contractor has acted or failed to act as follows:
 - 1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Agreement with the EOHHS, to a Member covered under this Agreement.
 - 2. Imposes on members' premiums or charges that are in excess of any permitted by the EOHHS.
 - 3. Acts to discriminate against Members on the basis of their health status or need for health care services. This includes the termination of enrollment or refusal to reenroll a Member, except as permitted by the EOHHS, or any practice that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services.
 - 4. Misrepresents or falsifies information that it furnishes to CMS or to the EOHHS.
 - 5. Misrepresents or falsifies information that it furnishes to a Member, a potential Member, or health care provider.
 - 6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208^{xxxviii} and 422.210.
- (b) EOHHS determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the EOHHS or that contain false or materially misleading information.
- (c) EOHHS determines that:
 - 1. The Contractor has violated any of the other applicable requires of sections 1932, 1903(m) or 1905(t)(3) of the Social Security Act and any implementing regulations;
 - 2. For any of the violations under 42 CFR 438.700(d)(1) and (2), only the sanctions specified in 42 CFR 438.702(a)(3), (4) and (5) may be imposed.

3.07.04.05 Types of Intermediate Sanctions

EOHHS may impose the following types of intermediate sanctions:

- 1. Civil monetary penalties in the amounts specified in 42 CFR 438.704^{xl ix}.

2. Appointment of temporary management for the Contractor as specified 42 CFR 438.706^{xlvi}.
3. Granting members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll.
4. Suspension of new enrollment, including default enrollment, after the effective date of the sanction.
5. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

EOHHS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700^l, as well as any additional areas of noncompliance. As set for in 42 CFR 438.710(a), EOHHS will provide the Contractor written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

3.07.04.06 Amount of Civil Monetary Penalties

The limit on, or the maximum civil monetary penalty EOHHS may impose varies depending on the nature of the Contractor's action or failure to act, as provided in this section.

1. The limit is \$25,000 for each determination under the following paragraphs of 42 CFR 438.700^l:
 - i. Paragraph (b)(1): Failure to provide services.
 - ii. Paragraph (b)(5): Misrepresentation or false statements to Members, potential Members, or health care providers.
 - iii. Paragraph (b)(6): Failure to comply with physician incentive plan requirements.
 - iv. Paragraph (c): Marketing violations.
2. The limit is \$100,000 for each determination under the following paragraphs of 42 CFR 438.700^l:
 - i. Paragraph (b)(3): Discrimination.
 - ii. Paragraph (b)(4): Misrepresentation or false statements to CMS or to the EOHHS.

The limit is \$15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice under paragraph (b)(3) of 42 CFR 438.700^l. This is subject to the overall limit of \$100,000 under paragraph (b)(3) of this section.

3.07.04.07 Compliance with Other Material Contract Provisions

The objective of this standard is to provide the State with an administrative procedure to address

general compliance issues under this Agreement which are not specifically defined as performance requirements listed above or for which damages due to non-compliance cannot be quantified in the manner described in Section 3.07.04.01.

The State may identify contractual compliance issues resulting from the Contractor's performance of its responsibilities through routine contract monitoring activities. If this occurs, the EOHHS Administrator or designee will notify the Contractor in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than thirty (30) calendar days, in which the Contractor must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the Contractor should remedy the non-compliance, but not less than thirty (30) days.

If the non-compliance is not corrected by the specified date, the State may assess damages up to the amount of two thousand five hundred dollars (\$2,500.00) per day after the due date until the non-compliance is corrected.

3.07.05 Deduction of Damages from Payments

Amounts due the State as damages may be deducted by the State from any money payable to the Contractor pursuant to this Agreement. The Contract Administrator will notify the Contractor in writing of any claim for damages at least fifteen (15) days prior to the date the State deducts such sums from money payable to the Contractor.

The State may, at its sole discretion, return a portion or all of any damages collected as an incentive payment to the Contractor for prompt and lasting correction of performance deficiencies.

3.07.06 Payments Denied by CMS

The State may recommend that CMS impose a denial of payment for new enrollees pursuant to 42 CFR 438.730. If the State's determination becomes CMS' determination, the State will:

- Provide the Contractor with written notice of the basis of the proposed sanction.
- All the Contractor fifteen (15) days from the date it received the notice to provide evidence contesting the basis for the sanction.
- Conduct a reconsideration, if requested by the Contractor
- Provide the Contractor a written decision setting forth the basis for the reconsideration decision.

If the Contractor does not seek reconsideration, the denial of payment will be effective fifteen (15) days after the date the Contractor is notified.

3.07.07 Intermediate Sanctions

EOHHS may establish intermediate sanctions, as specified in CFR 438.702 and 438.704, which it will impose if it makes any of the following determinations or findings from onsite surveys, enrollee or other complaints, financial status or any other source:

1. EOHHS determines that a Contractor acts or fails to act as follows:
 - a. Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a civil monetary penalty of up to \$25,000 for each instance of discrimination.
 - b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; the maximum amount of the penalty is \$25,000 or double the amount of the excess charges, whichever is greater.
 - c. Acts to discriminate among enrollees on the basis of their health status or need for health care services; the limit is \$15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice, subject to an overall limit of \$100,000.
 - d. Misrepresents or falsifies information that it furnishes to CMS or to EOHHS; EOHHS may impose a civil monetary penalty of up to \$100,000 for each instance of misrepresentation.
 - e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider; EOHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation.
 - f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210; EOHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply.
 - g. EOHHS determines whether the Contractor has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by EOHHS or that contain false or materially misleading information. EOHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply.
 - h. EOHHS determines whether the Contractor has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

In addition to any civil monetary penalty levied against the Contractor, EOHHS may also:

- Appoint temporary management to the Contractor;
- Grant Members the right to disenroll without cause;
- Suspend all new enrollment to the Contractor;
- Suspend payment for new enrollments to the Contractor

As set for in 42 CFR 438.710(a), EOHHS will give the Contractor written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

3.07.08 COMPLIANCE AUDIT AND CORRECTIVE ACTION

The Annual Compliance Audit will be onsite and consists of a focused review of key elements of the Contractor's compliance program (42 CFR 438.608) ^{xlili} and will assess adherence to the Contractor's written compliance plan including all relevant operating policies, procedures, workflows, and relevant chart of organization. The key elements reviewed may vary from year to year. A review of administrative and management arrangements may also be conducted as part of the annual audit. A review of grievance and appeal files will be a standard part of the compliance audit.

EOHHS will provide feedback to Contractor on the audit elements. If the audit reveals issues of noncompliance, EOHHS, at its discretion, will make the determination if a corrective action plan will be required to remediate any issues of noncompliance.

Issues of noncompliance and/ or under performance by the Contractor or their sub-contractors, either self-reported, discovered through audit or identified by EOHHS may, at the State's discretion, may require implementation of a Corrective Action Plan. Dependent on the severity of the issue of noncompliance and/or underperformance by the Contractor, EOHHS will implement Corrective Action Plan in accordance with time frames established by EOHHS. If the issue(s) of noncompliance and/or underperformance warrants continued monitoring or the issue(s) has occurred previously within the same contract year, EOHHS at its discretion, can require ongoing monitoring throughout the life of the contract or impose specific reporting to be submitted not otherwise stated in this Contract.

3.08 INSPECTION OF WORK PERFORMED

3.08.01 Access to Information

Pursuant to Section 434.6(a)(5), EOHHS, other state agencies, and/or its designees, including its management and external quality review organization contractors, the Medicaid Fraud Unit of the Department of Attorney General, and CMS and/or its designees, will have access to medical information, quality of service information, financial information (including claim level detail), service delivery information including authorization requests and denials or other adverse decisions, complaints, grievances and appeals information, and other such information of the Contractor, and its subcontractors and agents in order to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed and reimbursed for under this Agreement and in compliance with this Agreement. The Contractor agrees to accommodate requests for access to this information which may be submitted at any time.

Subcontractors must agree to comply with all applicable requirements, such as those pertaining to reporting responsibilities, record-keeping, state and federal audits. For audit purposes, subcontractors are subject to a 10-year record retention period for which EOHHS may request access to.

3.08.02 Inspection of Premises

The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General or their authorized representatives will, during normal business hours, have the right to enter into the premises of the Contractor and/or all subcontractors and providers, or such other places where duties under this Agreement are being performed, to inspect, monitor, or otherwise evaluate the work being performed.

Such inspections may include, but not be limited to, the CMS or State-mandated annual operational and financial Health Plan reviews, determinations of compliance with this Agreement, and CMS or State-mandated independent evaluations. All inspections and evaluations will be performed in such a manner as to not unduly interfere with or delay work.

3.08.03 Approval of Written Materials

The Contractor agrees to submit to EOHHS for review and approval all materials in any media. The Contractor produces for dissemination to actual and potential members including but not limited to materials produced for recipient education, outreach, marketing, the member handbook, and written grievance procedures. EOHHS will review such documents in draft form and determine whether to grant approval for the Contractor to disseminate such documents to the recipient population.

The Contractor's policies and procedures pertaining to the program covered under this Agreement produced for dissemination to actual and potential members, including but not limited to procedures for determining eligibility for coverage as a related group, also will be subject to inspection and approval by the State.

3.09 CONFIDENTIALITY OF INFORMATION

3.09.01 Maintain Confidentiality of Information

The Contractor will take security measures to protect against the improper use, loss, access of and disclosure of any confidential information it may receive or have access to under this Agreement as required by this Agreement, the RFP and proposal, or which becomes available to

the Contractor in carrying out this Agreement and the RFP and the proposal, and agrees to comply with the requirements of the EOHHS for safeguarding of client and such aforementioned information. Confidential information includes, but is not limited to: names, dates of birth, home and/or business addresses, social security numbers, protected health information, financial and/or salary information, employment information, statistical, personal, technical and other data and information relating to the State of Rhode Island data, and other such data protected by the office laws, regulations and policies ("confidential information"), as well as State and Federal laws and regulations. All such information will be protected by the Contractor from unauthorized use and disclosure and will be protected through the observance of the same or more effective procedural requirements as are applicable to the EOHHS.

The Contractor expressly agrees and acknowledges that said confidential information provided to and/or transferred to provider by the EOHHS or to which the Contractor has access to for the performance of this Agreement is the sole property of the EOHHS and will not be disclosed and/or used or misused and/or provided and/or accessed by any other individual(s), entity(ies) and/or party(ies) without the express written consent of the EOHHS. Further, the Contractor expressly agrees to forthwith return to the EOHHS any and all said data and/or information and/or confidential information and/or database upon the EOHHS's written request and/or cancellation and/or termination of this Agreement.

The Contractor will not be required under the provisions of this paragraph to keep confidential any data or information, which is or becomes legitimately publicly available, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of this Agreement or is rightfully obtained from third parties under no obligation of confidentiality.

The Contractor agrees to abide by all applicable, current and as amended Federal and State laws and regulations governing the confidentiality of information, including to but not limited to the Business Associate requirements of HIPAA (WWW.HHS.GOV/OCR/HIPAA), to which it may have access pursuant to the terms of this Agreement. In addition, the Contractor agrees to comply with the EOHHS confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information. ("Confidential records" are the records as defined in section 38-2-3(d) of the Rhode Island General Laws, entitled "access to public records" and described in "access to Department of Health records.")

In accordance with this Agreement and all Addenda thereto, the Contractor will additionally receive, have access to, or be exposed to certain documents, records, that are confidential, privileged or otherwise protected from disclosure, including, but not limited to: personal information; Personally Identifiable Information (PII), Sensitive Information (SI), and other information (including electronically stored information), records sufficient to identify an applicant for or recipient of government benefits; preliminary draft, notes, impressions, memoranda, working papers-and work product of state employees; as well as any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court ("State Confidential Information"). State Confidential Information also includes PII and SI as it pertains to any public assistance recipients as well as retailers within the SNAP Program and Providers within any of the State Public Assistance programs.

Personally Identifiable Information (PII) is defined as any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual. (As defined in 45 CFR 160.103).

Sensitive Information (SI) is information that is considered sensitive if the loss of confidentiality, integrity, or availability could be expected to have a serious, severe or catastrophic adverse effect on organizational operations, organizational assets, or individuals. Further, the loss of sensitive information, confidentiality, integrity, or availability might: (i) cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions; (ii) result in significant or major damage to organizational assets; (iii) result in significant or major financial loss; or (iv) result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life threatening injuries. (Defined in HHS Memorandum ISP-2007-005, "Departmental Standard for the Definition of Sensitive Information").

The Contractor agrees to adhere to any and all applicable State and Federal statutes and regulations relating to confidential health care and substance Use treatment including but not limited to the Federal Regulation 42 CFR, Part 2; Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26; Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq., and HIPAA 45 CFR Part 160^{lii}. The Contractor acknowledges that failure to comply with the provisions of this paragraph will result in the termination of this Agreement.

EOHHS requires the Contractor to adhere to the provisions of the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, as well as guidelines found in the "Health Information Technology for Economic and Clinical Health Act" (HITECH). The Contractor will require HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information and must specify the requirements of these notifications to the HIPAA covered entities and business associates. In addition, EOHHS requires the Contractor to notify EOHHS immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use of disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality or integrity of enrollee PHI maintained or held by the Contractor, including unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor's system. Additionally, a breach or suspected breach may be an actual or suspected acquisition, access, use of, or disclosure of PII or SI. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs and/or disks. Notification to EOHHS' designated security officer will be made by telephone call and e-mail. The Contractor will, within three (3) business days, provide to the EOHHS's designated security officer an updated status of the breach. A full report is required to be submitted to EOHHS's designated security officer within sixty (60) calendar days and will include a full accounting of

the incident along with a corrective action plan.

Upon notice of a suspected security incident, the EOHHS and the Contractor will meet to jointly develop an incident investigation and remediation plan. Depending on the nature and severity of the confirmed breach, the plan may include the use of an independent third-party security firm to perform an objective security audit in accordance with recognized cyber security industry commercially reasonable practices. The parties will consider the scope, severity and impact of the security incident to determine the scope and duration of the third-party audit. If the parties cannot agree on either the need for or the scope of such audit, then the matter will be escalated to senior officials of each organization for resolution. The Contractor will pay the costs of all such audits. Depending on the nature and scope of the security incident, remedies may include, among other things, information to individuals on obtaining credit reports and notification to applicable credit card companies, notification to the local office of the Secret Service, and or affected users and other applicable parties, utilization of a call center and the offering of credit monitoring services on a selected basis.

Notwithstanding any other requirement set out in this Agreement, the Contractor acknowledges and agrees that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements will be implemented by regulations to be adopted by the U.S. Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and its implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

Failure to abide by the EOHHS's confidentiality policy or the required signed Business Associate Agreement (BAA) will result in termination remedies, including but not limited to, termination of this Agreement. A Business Associate Agreement (BAA) will be signed by the Contractor, simultaneously or as soon thereafter as possible, from the signing of this Agreement, as required by the EOHHS.

3.09.02 Confidentiality of Information

The Contractor agrees that all information, records and data collected in connection with this contract will be protected from unauthorized disclosures and will be used by the Contractor personnel solely for purposes directly connected with the Contractor's performance of this Agreement. In addition, the Contractor agrees to safeguard the confidentiality of qualified member information. Access to member identifying information will be limited by the Contractor to persons, Health Plans or agencies, which require the information in order to perform their duties in accordance with this Agreement.

Any other person or entity will be granted access to confidential information only after

complying with the requirements of the State and Federal laws and regulations pertaining to such access. Nothing herein will prohibit the disclosure of information in summary, statistical or other form, which does not identify the particular individuals.

The Contractor agrees to comply with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42U.S.C. Section 1320d, et seq., and regulations promulgated there under, as amended from time to time (statute and regulations hereinafter collectively referred to as the “privacy rule”).

The Contractor’s obligations and responsibilities:

- (a) The Contractor agrees to not use or disclose protected health information other than is permitted or required by the agreement or as required by law.
- (b) The Contractor agrees to use appropriate and most updated industry safeguards to prevent use or disclosure of the protected health information other than as provided by this agreement.
- (c) The Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or a disclosure of protected health information by the Contractor in violation of requirement of this Agreement.
- (d) The Contractor agrees to report to EOHHS any use or disclosure of the protected health information not provided for by this Agreement of which it becomes aware.
- (e) The Contractor agrees to maintain the security of protected health information it receives by establishing, at a minimum, measures utilized in current industry standards.
- (f) The Contractor agrees to notify EOHHS immediately upon becoming aware of a suspected or actual breach of security that may result or has resulted in the use or disclosure of protected health and other confidential information for purposes other than such proposed as specified in this Agreement.
- (g) The Contractor agrees to prepare and maintain a plan, subject to review by EOHHS /Do IT upon request, specifying the method that the Contractor will employ to mitigate immediately, to extent practicable, any harmful effects that may or have been caused by such a breach.
- (h) The Contractor agrees that EOHHS will be held harmless in the event of such a breach and the Contractor accepts fully the legal and financial responsibility associated with mitigating any harmful effects that may or have been caused.
- (i) The Contractor agrees that it is subject to and will ensure compliance with all HIPAA regulations in effect at the time of this Agreement and as will be amended under HIPAA from time to time, and any and all reporting requirements required by HIPAA at the time of this Agreement and as will be amended, under HIPAA from

time to time. As well as ensuring compliance with the Rhode Island Confidentiality of Health Care Information Act, Rhode Island General Laws, Section 5-37.3 seq.

- (j) The Contractor agrees to implement policies and procedures to facilitate the removal, termination and final disposal of PHI in electronic format, including the storage media housing the information.

3.09.03 Assurance of Security and Confidentiality

Each party agrees to take reasonable steps to ensure the physical security of such data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files; guards; or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; such as passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; such as limited terminal access; limited access to input documents and output documents; and design provisions to limit use of client or applicant names.

Each party agrees that it will inform each of its employees having any involvement with personal data or other confidential information, whether with regards to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

In the event of the Contractor's failure to conform to requirements set forth above, EOHHS may terminate this Agreement under the provisions of Section 3.10 (Termination of the Contract).

3.09.04 Return of Confidential Data

The Contractor agrees to return all personal data furnished pursuant to this Agreement promptly at the request of the State in whatever form is maintained by the Contractor. Upon the termination or completion of the Agreement, the Contractor will not use any such data, or any material derived from the data for any purpose not permitted by law and where so instructed by the State will destroy such data or material if permitted by law.

3.09.05 Hold Harmless

The Contractor agrees to defend (subject to the approval of the Attorney General), indemnify, and hold harmless EOHHS and the State against any claim, loss, damage, or liability incurred as a result of any breach of the obligations of Section 3.09 by the Contractor or any subcontractor.

3.09.06 State Assurance of Confidentiality

The State agrees to ensure Federal and State laws of confidentiality are maintained to protect

member and provider information.

3.09.07 Publicizing Safeguarding Requirements

Pursuant to 42 CFR 431.304, the Contractor agrees to publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use. The Contractor will include these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

3.09.08 Types of Information to Be Safeguarded

Pursuant to 42 CFR 431.305 and HIPAA, and subject to any permitted uses under this Agreement, the Contractor agrees to maintain the confidentiality of recipient information regarding at least the following:

- Names, addresses, and social security numbers
- Physical and behavioral health services provided
- Social and economic conditions or circumstances
- EOHHS evaluations of personal information
- Medical data, including diagnosis and past history of diseases or disability and
- Any information received in connection with the identification of legally liable third-party resources

Pursuant to 42 CFR 431.305 and HIPAA, the State agrees to maintain the confidentiality of recipient information regarding at least the following:

- Any information received for verifying income eligibility and amount of Medicaid payments
- Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data

3.09.09 Confidentiality and Protection of Public Health Information and Related Data

The Contractor will be required to execute a Business Associate Agreement Data Use

Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, will require the successful Contractor to comply with 45 CFR 164.502(e), 164.504(e), 164.410^{liii}, governing Protected Health Information (“PHI”) and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated there under, and as amended from time to time the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, RI general Laws Section 5-37.3 et seq.

Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

The Contractor will be required to ensure, in writing that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this Agreement, agrees to have the same restrictions and conditions that apply through the above described Agreements with respect to such information.

3.10 TERMINATION OF THE CONTRACT

This Agreement between the parties may be terminated only on the following basis:

- By mutual written agreement of the State and the Contractor
- By the State, or by the Contractor, in whole or in part, whenever one party determines that the other party has failed to satisfactorily perform its contracted material duties and responsibilities and is unable to cure such failure within a reasonable period of time after receipt of a notice specifying that material breach.
- By the State, or the Contractor, in whole or in part, whenever funding from State, Federal, or other sources is withdrawn, reduced, or limited, with at least sixty (60) days prior written notice.
- By the State, in whole or in part, whenever the State reasonably determines, based on adequate documentation, that the instability of the Contractor's financial condition threatens delivery of covered services and continued performance of the Contractor responsibilities.
- Upon a finding of just cause, if the State will determine that such termination is in the best interest of the State, with sufficient prior notice to the Contractor.

- By either party pursuant to Section 3.05.03 (Contractor Certification of HMO Licensure) of this Agreement

As specified in 42 CFR 438.710(b), prior to terminating this Agreement, EOHHS will provide the Contractor with written notice of its intent to terminate, the reason(s) for termination, and the time and place of the pre-termination hearing. After the hearing, EOHHS will provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the contract. If the decision to terminate is affirmed, EOHHS will provide the Contractor with the effective date of the termination. If the decision to terminate is affirmed, EOHHS will notify members of the termination and their options for receiving Medicaid services following the effective date of the termination and allow members to disenroll without cause.

3.10.01 Termination for Default

The State or the Contractor may terminate this Agreement, in whole or in part, whenever either reasonably determines that the other party has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within a reasonable period of time as specified in writing by the State or the Contractor, as applicable. Such termination will be referred to herein as “Termination for Default.”

Upon reasonable determination by the State or the Contractor that the other party (the “Defaulting Party”) has failed to satisfactorily perform its contracted duties and responsibilities, the Defaulting Party will be notified in writing, by either certified or registered mail, of the failure. If the Defaulting Party is unable to cure the failure within sixty (60) days following the receipt of notice of default, unless a different time period is agreed to by the parties in writing, the State or the Contractor, as applicable, will notify the Defaulting Party that this Agreement, in whole or in part, has been terminated for default.

If, after notice of Termination for Default, it is determined by the State or the Contractor, as applicable, or by a court of law of competent jurisdiction that the Defaulting Party was not in default or that the Defaulting Party's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Defaulting Party, the termination will be deemed to be governed by Section 3.05.09 (Force Majeure) of this Agreement.

In the event of termination for default by the State, in full or in part as provided under this clause, the State may cover, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor will be liable for any costs for such similar supplies or services and all other damages allowed by law. In addition, the Contractor will be liable to the State for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. Payment for such costs may be assessed against the Contractor's performance bond or substitute security.

In the event of a termination for default by the State, the Contractor will be paid for any

outstanding monies due less any assessed damages. If damages exceed monies due from invoices, collection can be made from the Contractor's performance bond, cash deposit, letter of credit, or substitute security.

The rights and remedies of the State provided in this clause will not be exclusive and are in addition to any other rights and remedies provided by law or under the contract.

In the event of Termination for Default by the Contractor, in whole or in part as provided under this clause, the Contractor immediately may close to new enrollment that has been initiated but not yet completed as of the date specified in the notice of termination), without reduction of the premium rate for the then-current enrollees as provided in ATTACHMENT J. The Contractor will be paid for any capitation or other monies due through the date specified in the notice of termination, including risk sharing payment, within ninety (90) days of termination. The rights and remedies of the Contractor provided in this clause will not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

Any fraudulent activities may result in criminal prosecution.

3.10.02 Termination for Unavailability of Funds

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated contract expiration date, the State may terminate this Agreement upon at least thirty (30) days prior written notice.

In the event that the State elects to terminate this Agreement pursuant to this provision, the Contractor will be notified in writing by either certified or registered mail either thirty (30) days or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination will be effective as of the close of business on the date specified in the notice.

Upon receipt of notice of termination for unavailability of funds, the Contractor will be paid for any outstanding monies due.

3.10.03 Termination for Financial Instability

In the event that the State reasonably determines, based on adequate documentation, that the Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under this Agreement, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Agreement effective the close of business on the date specified. In the event the State elects to terminate this Agreement under this provision, the Contractor will be notified in writing by either certified or registered mail specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor will

immediately advise the Contract Administrator. The Contractor will ensure that all tasks related to the subcontract are performed in accordance with the terms of this Agreement.

3.10.04 Termination for Convenience

Upon written notice sent via certified mail to the EOHHS Officer, the Contractor may seek to terminate this Agreement with the EOHHS without cause. The Contractor will have a transition period of not less than four (4) nor more than six (6) months to transition services, during which time the term and conditions of this Agreement will continue to apply, and the Contractor will provide Covered Services to, and will be paid pursuant to the Capitation Rates set forth herein for each Member, up to and including the date of transition of such Member.

The Contractor will work in good faith with the EOHHS and the EOHHS' other Medicaid managed care Contractors to ensure the safe and orderly transition of the Contractor's Members into a new Health Plan.

3.10.05 Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective or upon expiration of this Agreement, the Contractor will:

- Stop work under this Agreement on the date and to the extent specified in the Notice of Termination or upon expiration of this Agreement.
- With the approval of the State, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts or from such expiration, the cost of which would be reimbursable in whole or in part, in accordance with the provision of this Agreement.
- If applicable, complete the performance of such part of the work as has not been terminated by any Notice of Termination.
- Provide all reasonably necessary assistance to the State in transitioning members out of the Health Plan generally, upon expiration of the Agreement, or to the extent specified in the Notice of Termination. Such assistance will include, but not be limited to, the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized and pregnant members in their last four weeks of pregnancy.
- Provide to the State on a monthly basis, until the earlier of six (6) months from the termination or expiration or instructed otherwise, a monthly, claims aging report by provider/creditor that includes IBNR amounts; a monthly summary of cash disbursements; and copies of all bank statements received by the Contractor in the

preceding month. Such reports will be due on the fifteenth (15th) working day of each month for the prior month.

3.10.06 Refunds of Advance Payments

The Contractor will return within thirty (30) days of receipt any funds advanced for coverage of members for periods after the date of termination or expiration.

3.10.07 Liability for Medical Claims

The Contractor will be liable for all medical claims incurred up to the date of termination. This will include the hospital inpatient claims incurred for members hospitalized at the time of termination. In the event of termination of solvency, the Contractor is responsible for payment for services received by members in any month for which capitation was paid, as well as for the relevant portion of inpatient services for members hospitalized at time of termination.

3.10.08 Termination Claims

After receipt of a Notice of Termination, the Contractor will submit any termination claims in the form and with the certifications prescribed by the State. Such claims will be submitted promptly, but in no event later than six (6) months from the effective date of termination, unless one or more extensions in writing are granted by the State within such six- (6) month period or authorized extension thereof.

Subject to the timeliness provisions in the previous paragraph, and subject to any review required by State procedures in effect as of the date of execution of the contract, the Contractor and State may agree upon the amounts to be paid to the Contractor by reason of the total or partial termination of work. This Agreement will be amended accordingly (see Section 3.03, *Contract Amendments*).

In the event of a failure to agree in whole or in part as to the amounts to be paid to the Contractor in connection with the total or partial termination of work pursuant to this Article, the State will determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and will pay to the Contractor the amount so determined. The Contractor will have the right of appeal, as stated under Section 3.02.05, (Disputes), of any such determination.

However, if the State determines that the facts justify such action, termination claims may be accepted and acted upon at any time after such six (6) month period or any extension thereof. Upon failure of the Contractor to submit its termination claim within the time allowed, the State may, subject to any review required by the State procedures in effect as of the date of execution of the contract, determine on the basis of information available the amount, if any, due to the

Contractor by reason of the termination and will pay to the Contractor the amount so determined.

In no case will the Contractor's termination claims include any claim for unrealized anticipatory profits.

3.10.09 Notification of members

In the event that this Agreement is terminated for any reasons outlined in above, or in the event that this Agreement is not renewed for any reason, EOHHS in consultation with the Contractor regarding the content of any notice (such consultation to occur prior to the sending of any notice) will be responsible for notifying all members covered under this Agreement of the date of termination and the process by which those members will continue to receive Covered Services.

3.10.10 Non-Compete Covenant

EOHHS may cancel this Agreement without penalty, if any person significantly involved in negotiating, securing, drafting, or creating this Agreement on behalf of the State is or becomes at any time, while this Agreement or any extension of this Agreement is in effect, an employee of any party to this Agreement in any capacity or a consultant to the Contractor or Subcontractor with respect to the subject matter in this Agreement. Cancellation will be effective when written notice from EOHHS is received by the Contractor unless the notice specifies a later time.

3.11 OTHER CONTRACT TERMS AND CONDITIONS

3.11.01 Environmental Protection

The Contractor will comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR, Part 15) which prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable grantor Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

3.11.02 Ownership of Data and Reports

Data, information, and reports collected or prepared directly for the State by the Contractor in the course of performing its duties and obligations under this Agreement will be deemed to be owned by the State of Rhode Island. This provision is made in consideration of the Contractor's use of public funds in collecting or preparing such data, information, and reports. Nothing contained herein will be deemed to grant to the State ownership or other rights in the Contractor's proprietary information systems or technology used in conjunction with this

Agreement.

3.11.03 Publicity

Any publicity given to the program or services provided herein, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor, will identify the State of Rhode Island as the sponsor and will not be released without prior written approval from the State.

3.11.04 Award of Related Contracts

The State may undertake other contracts for work related to this Agreement or any portion thereof. Examples of other such contracts include, but are not limited to, contracts with other Health Plans to provide Medicaid Managed Care services and contracts with management firms to assist in administration of this Agreement. The Contractor will be bound to cooperate fully with such other Contractors as directed by the State in all such cases. All subcontractors will be required to abide by this provision as a condition of the contract between the subcontractor and the prime Contractor.

3.11.05 Conflict of Interest

No official or employee of the State of Rhode Island or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement will, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in the contract or proposed contract. All State employees will be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

The Contractor represents and covenants that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that, in the performance of the contract, no person having any such known interests will be employed.

3.11.06 Reporting of Political Contributions

In accordance with Rhode Island Executive Order 91-31, any Contractor who obtains a State contract or purchase order for goods or services, and whose charges to the State exceed two thousand five hundred dollars (\$2,500.00) in any State fiscal year, is required to file a form declaring the vendor's political contributions in excess of two hundred dollars (\$200.00) to candidates for State offices or the General Assembly. Upon payment to a Contractor being made in excess of two thousand five hundred dollars (\$2,500.00) year-to-date, the Contractor will receive a form prepared by the Secretary of State upon which to make such declaration. The Contractor will update such form as future political contributions subject to this reporting

requirement are made. Failure to complete or update said form accurately, completely, and in conformance with its terms, or to file it with the Secretary of State within sixty (60) days of receipt, will amount to a violation of these terms and conditions and may render the Contractor ineligible for further State contracts. Additional disclosure forms, as may be required, may be obtained from the office of the Secretary of State.

3.11.07 Environmental Tobacco Smoke

The Contractor will comply with Public Law 103-227, Part C—Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

3.11.08 Titles Not Controlling

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and will not be construed to infer a contractual construction of language.

3.11.09 Other Contracts

Nothing contained in this Agreement will be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor will provide EOHHS with a complete list of such plans and services, including rates, upon request. Nothing in this Agreement will be construed to prevent EOHHS from contracting with other comprehensive health care plans in the same enrollment area. EOHHS shall not disclose any proprietary information pursuant to this information except as required by law.

3.11.10 Counterparts

This Agreement may be executed simultaneously in two or more counterparts each of which will be deemed an original and all of which together will constitute one and the same instrument.

3.11.11 Administrative Procedures Not Covered

Administrative procedures not provided for in this Agreement will be set forth where necessary in separate memoranda from time to time in accordance with Section 3.01.09.

These administrative procedures will include but will not be limited to participation in meetings and file exchanges with Health Source RI, the Unified Health Information Project (UHIP) and all other vendors and subcontractors involved in implementing the Medicaid eligibility system in RI.

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

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES:**

BY:


(Signature)

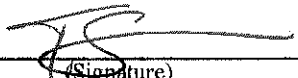
Patrick M. Tighe
(Printed Name)

Assistant Secretary for Health and Medicaid Director
(Official Title)

10/10/19
(Date)

UNITEDHEALTHCARE OF NEW ENGLAND:

BY:


(Signature)

TIMOTHY SPILKER
(Printed Name)

SENIOR Vice President
(Official Title)

10-2-19
(Date)

