TUFTS HEALTH PUBLIC PLANS

AMENDMENT NO. 10

THIS AGREEMENT, AMENDMENT NO. 10, is made and entered into effective July 1, 2023, between the State of Rhode Island (formerly known as the State of Rhode Island and Providence Plantations), Executive Office of Health and Human Services (hereinafter referred to as 'EOHHS" or the "State") and Tufts Health Public Plans (hereinafter referred to as "Contractor").

WHEREAS, EOHHS and Contractor entered into a CONTRACT BETWEEN STATE OF RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES AND TUFTS HEALTH PUBLIC PLANS FOR MEDICAID MANAGED CARE SERVICES dated March 1, 2017 (hereinafter referred to as "Agreement").

WHEREAS, the original Agreement identified above, together with any and all previously executed amendments, and all its terms and conditions remain unchanged except as modified in this Amendment No. 10.

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

CONTRACT EXTENSION: Parties agree to a twelve (12) month extension as described in Request for Proposals Solicitation # 7550787. Effective date of extension is July 1, 2023, through June 30, 2024.

ARTICLE I: DEFINITIONS

1. **Section 1.08 AFFILIATE** is amended by ***INSERTING*** the following definition, "Any person, firm, corporation, partnership, limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor."

2. **Section 1.12 ALTERNATIVE PAYMENT METHOD (APM),** is amended by ***INSERTING*** the following definition, "A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to specific clinical conditions, care episodes, or populations."

3. **Section 1.19 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC)**, is amended by ***INSERTING*** the following definition, "A CCBHC is an EOHHS certified entity providing a comprehensive array of behavioral health services. The Excellence in Mental Health and Addiction Act demonstration established a federal definition and criteria for CCBHCs. CCBHCs are non-profit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine (9) types of services, with an emphasis on the provision of twenty-four (24) hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care."

4. **Section 1.20 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DESIGNATED COLLABORATING ORGANIZATION (CCBHC-DCO)** is amended by ***INSERTING*** the following definition, "A Certified Community Behavioral Health

Clinic Designated Collaborating Organization (CCBHC DCO) is a provider with whom a CCBHC has a formal written agreement establishing a relationship to provide certain allowable services on behalf of the CCBHC."

5. **Section 1.52 HBTS/ABA** is amended by ***INSERTING*** the following definition, "Refers to home based therapeutic services and/or applied behavior analysis therapy as described in the Rhode Island Certification Standards for Providers of Home- Based Therapeutic Services (July 1, 2016)."

6. **Section 1.75 INFORMED CHOICE**, is amended by ***INSERTING*** the following definition, "Refers to the process by which the State ensures that a parent or guardian of a child determined eligible for services under "Katie Beckett" has an opportunity to make an informed decision about where his or her child will receive services. Informed Choice means a choice made after the State has provided Person-centered Planning and information about the various services that the child is eligible and appropriate to receive. Informed Choice also entails making reasonable efforts to identify and address any concerns or objections raised by the parent or guardian of a child determined eligible for services under "Katie Beckett"."

7. **Section 1.77 KATIE BECKETT**, is amended by ***INSERTING*** the following definition, "Refers to an eligibility category in the Rhode Island Medical Assistance (Medicaid) Program that provides medical assistance coverage for certain children under age nineteen (19) who have long-term disabilities or complex medical needs and who live at home. Children eligible for Katie Beckett services may receive those services at home instead of in an institution."

8. **Section 1.85 MENTAL HEALTH BENEFITS**, is amended by ***INSERTING*** the following definition, "Benefits for items or services for mental health conditions, as defined by EOHHS and in accordance with applicable Federal and State law. For purposes of this Agreement, substance use disorder benefits include the long-term care services described in Section 3.4, "Behavioral Health". [42 C.F.R. § 438.900]"

9. **Section 1.97 PERSON-CENTERED PLANNING**, is amended by ***INSERTING*** the following definition, "The formal process, consistent with the requirements of 42 C.F.R. § 441.725, that organizes services and supports around a self-directed, self- determined, and goal-directed future. This includes the process by which a child's family or guardian, with the assistance of appropriate State personnel or contracted entities, Provider Agency staff, and/or healthcare professionals, identifies the most integrated setting appropriate for the child and the services necessary to enable the child to reside in the most integrated setting."

10. **Section 1.132 SOCIAL DETERMINANTS OF HEALTH (SDoH),** is amended by ***INSERTING*** the following definition, "The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

11. **Section 1.133 SOCIAL RISK FACTORS,** is amended by ***INSERTING*** the following definition, "Adverse social conditions (e.g., homelessness, social isolation, low education level, etc.) specific to individuals that increase their likelihood of poor health."

12. **Section 1.143 TREATMENT LIMITATIONS,** is amended by ***INSERTING*** the following definition, "Include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as fifty (50) outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See 42 C.F.R. § 438.910(d)(2) for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. [42 C.F.R. § 438.900]"

13. **Section 1.147 VALUE-ADDED SERVICES (VAS)**, is amended by ***INSERTING*** the following definition, "Additional services the Contractor offers to Members beyond the Covered Services specified in Attachment A, "Schedule of In-Plan Benefits." Value-Added Services shall be pre-approved in writing by EOHHS, and may be actual Health benefits, or positive incentives that EOHHS determines will promote healthy lifestyles, address social determinants of health, or improve health outcomes among Members."

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

14. **Section 2.03.02 Other Administrative Components** is amended by ***INSERTING*** a bullet to the end of the section as follows:

    - "Chief Diversity, Equity, and Inclusion Officer."

15. **Section 2.06.01.02 Medical Services** is amended by adding the following: "… and must comply with the following requirements:

    1. Each Covered Service must be provided in an amount, duration, and scope that is no less than the amount, duration, and scope for the same service under Rhode Island's fee-for-service Medicaid program.
    2. The Contractor must ensure that Covered Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which they are furnished.
    3. The Contractor will not arbitrarily deny or reduce the amount, duration, or scope of Covered Services solely because of the diagnosis, type of illness, or condition of the Member.
    4. Covered Services are subject to the benefit limits described in the Rhode Island Medicaid State Plan. The Contractor may place appropriate limits on Covered Services based on Medical Necessity or for the purpose of utilization control.
    5. The Contractor must ensure, notwithstanding any utilization controls:
        a. Services can reasonably achieve their purpose.
        b. Services are authorized in a manner to reflect a Member's ongoing need for services and supports, taking into account Members with ongoing or chronic conditions.

c. Family planning and women's health services are provided in a manner that maintains the Member's freedom of choice as required in Sections 3.14.38 and 3.14.39 of this Agreement."

16. Section **2.06.01.07 Telehealth** is amended by ***RENAMING*** the section to "**Telemedicine**" and ***DELETING*** the language in its entirety and ***REPLACING*** it with the following new language:

"Definitions

For purposes of this section, the following terms are defined in accordance Rhode Island General Laws, Chapter 27-81, the "Telemedicine Coverage Act" [RI Gen. Laws 27-81-3] to mean:

Clinically Appropriate means care that is delivered in the appropriate medical setting.

Distant Site means a site at which a Healthcare Provider is located while providing Healthcare Services by means of telemedicine.

Healthcare Facility means an institution providing Healthcare Services or a healthcare setting, including, but not limited to hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings.

Healthcare Professional means a physician or other healthcare practitioner licensed, accredited, or certified to perform specified Healthcare Services consistent with Rhode Island law.

Healthcare Provider means a Healthcare Professional or a Healthcare Facility.

Healthcare Services means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

Medically Necessary means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition, including such services necessary to prevent a decremental change in either medical or mental health status.

Originating Site means a site at which a patient is located at the time Healthcare Services are provided to them by means of telemedicine, which can be include a patient's home where Medically Necessary and Clinically Appropriate.

Store-and-forward Technology means the technology used to enable the transmission of a patient's medical information from an Originating Site to the Healthcare Provider at the Distant Site without the patient being present.

Telemedicine means the delivery of clinical Healthcare Services by use of real time, two-way synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology including, but not limited to: online adaptive

interviews, remote patient monitoring devices, audiovisual communications, including the application of secure video conferencing and store-and-forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, counseling and prescribing treatment, and care management of a patient's health care while such patient is at an Originating Site and the Healthcare Provider is at a Distant Site, consistent with applicable federal laws and regulations. "Telemedicine" does not include an email message or facsimile transmission between a Provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

General Requirements

Telemedicine is an approved mode of delivering a Healthcare Service when:

a) The Service is a Medically Necessary Covered Service under this Agreement; and

b) It is Clinically Appropriate to provide the service via Telemedicine.

The Contractor must comply with the requirements of Section 3-27-81-4 of the Rhode Island Telemedicine Coverage Act, which prohibits the Contractor from:

a) Excluding a Healthcare Service from coverage solely because it is provided through Telemedicine and not via in-person consultation or contact.

b) Reimbursing Network PCPs, registered dietician nutritionists, and behavioral health Providers for Telemedicine services at rates lower than services delivered by the same Provider in person.

c) Imposing a deductible, copayment, or coinsurance requirement for a Healthcare Service delivered via Telemedicine above what would normally be charged for an in-person service (applicable if EOHHS implements cost- sharing requirements for Medicaid Members).

d) Imposing Prior Authorization or other UM requirements for a Telemedicine service that are more stringent than those required for the same in-person service.

e) Imposing more stringent medical or benefit determination requirements for a Telemedicine service than those required for the same in-person service.

f) Imposing restrictions on specific technologies used to deliver Telemedicine services, unless authorized by state or federal law, EOHHS guidance, or other applicable state regulatory requirements.

The Contractor is also prohibited from imposing restrictions on Originating Sites or Distant Sites for Telemedicine services, unless authorized by State or federal law, EOHHS guidance, or other applicable State regulatory requirements.

Section 27-81.7 of the Rhode Island Telemedicine Coverage Act requires the Contractor to submit reports to the Office of the Health Insurance Commissioner (OHIC) regarding its telemedicine policies, practices, and experience. The Contractor must provide EOHHS copies of all such OHIC reports within three (3) Business Days of filing.

The Compliance Plan described in Section 2.18, "Compliance," must include the Contractor's policies and procedures for demonstrating compliance with this Section and

the Telemedicine Coverage Act. The Contractor will assist EOHHS and the officials with audits or reviews of payment parity, utilization management, and other telemedicine requirements.

Provider Requirements

The Contractor must ensure Healthcare Providers meet state, federal, and EOHHS requirements for:

a) Participating in the Medicaid program;

b) Coding Telemedicine claims; and

c) Prescribing medications via Telemedicine, including the 21 U.S.C. § 829 and Drug Enforcement Administration (DEA) restrictions on prescribing controlled substances.

Any Healthcare Professional providing Healthcare Services via Telemedicine will be subject to the same standard of care or practice standards as applicable to in-person settings.

As specified in Section 3.05.13, "Payments to Institutions or Entities Located Outside of the U.S." and 42 C.F.R. § 438.602(i), the Contractor is prohibited from making payments to Telemedicine providers located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Marina Islands and American Samoa.

In accordance with Section 2.11.1, "Provider Manual," the Contractor's Provider Manual must include clear instructions on how to:

a) Request Prior Authorization for Telemedicine Services.

b) Submit claims for Telemedicine Services.

c) Direct Members to in-person care when Telemedicine services are not Medically Necessary or Clinically Appropriate.

Member Education

In accordance with Section 2.10, "Member Services," the Contactor must educate Members about the availability of Telemedicine services and include clear instructions on how to access Healthcare Services through Telemedicine on the Contractor's website and in the Member Handbook."

17. **Section 2.06.01.10 In Lieu of Services** is amended by ***DELETING*** the language in its entirety and ***REPLACING*** it with the following new language: "The Contractor may offer In-Lieu of Services (ILOS), as approved by EOHHS, in accordance with the policies and procedures defined in *EOHHS MCO Core Contract Requirements for Requesting In Lieu of Services.* ILOS may be substituted for a Rhode Island Medicaid State Plan service when all of the following conditions are met:

a) EOHHS, in its sole discretion, determines the alternative service or setting is a medically appropriate substitute for the Covered Service or setting under the Rhode Island Medicaid State Plan.

b) EOHHS, in its sole discretion, determines the alternative service or setting is a cost-effective substitute for the Covered Service or setting under the State Plan.

c) The approved ILOS is listed in Attachment A, "In-Lieu of Services."

In its approval of the ILOS, EOHHS will designate a CPT code and fee schedule rate and other billing and coding guidelines, as appropriate.

The Contractor must submit claims for ILOS using the designated code and rate. Further the Contractor must follow all EOHHS billing and coding guidelines applicable to that ILOS.

The Contractor may not offer an ILOS until EOHHS has submitted a written notice of approval of the ILOS and its CPT code and rate and notified the Member as outlined in this Section.

The Contractor may not require the Member to receive the ILOS in place of the Rhode Island Medicaid State Plan service.

The Contractor must inform Members of any newly approved ILOS on its website and in an update to the Member Handbook. All updates must be posted no later than thirty (30) Days after EOHHS' approval of the ILOS.

If the Contractor seeks to provide an ILOS that is not listed in Attachment A, it must receive EOHHS' prior approval to delivery of the ILOS.

Termination of an In-Lieu of Service

EOHHS, in its sole discretion, may terminate an ILOS if it determines that the service is not cost effective or may be harmful to Members. EOHHS will provide notice to the Contractor of its decision to terminate.

The Contractor may terminate its offer of an ILOS after receiving written approval from EOHHS to do so. The Contractor must submit their intent to terminate an ILOS in accordance with Section 3 of the *EOHHS MCO Core Contract Requirements for Requesting In Lieu of Services.*

The Contractor must notify Members of an ILOS termination, regardless of whether EOHHS or the Health Plan initiated the termination. The Contractor must post notice on its website and in an update to the Member Handbook. All updates must be posted no later than thirty (30) days in advance of the termination date.

The Contractor must develop a transition plan for Members receiving the terminated ILOS and ensure Subcontractors and Providers follow the transition plan or otherwise maintain continuity of care for Members.

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 services provided in an Institution for Mental Disease (IMD) for members between the ages of twenty-one (21) and sixty-four (64), subject to the limitations described in 42 C.F.R. § 438.6(e)."

18. **New Section 2.06.01.11 Value-Added Services,** is amended by ***ADDING*** the following:

"The Contractor may offer Value-Added Services to its Members, as approved by EOHHS in accordance the *EOHHS MCO Core Contract Requirements for Value-Add Services*.

EOHHS will not factor Value-Added Service into its calculation of the Contractor's Capitation Rate, meaning the Contractor is responsible for the cost of all Value-Added Services.

The Contractor must include a description of the Value-Added Services offering in all Member Materials as described in section 2.05.10 of this Agreement.

The Contractor may include use Value-Added Services offerings as a Marketing tool and include the service array in Marketing Materials.

a) The Contractor must share a description of the Value-Added Services offerings with EOHHS contracted entities providing Choice Counseling to help ensure Choice Counselors are accurately explaining the Value-Added Services in their communication with Members and Potential Members.

Terminating a Value-Added Service

The Contractor, in its sole discretion, may choose to discontinue a Value-Added Service.

Prior to terminating a Value-Added Service, the Contractor must notify the following entities:

a) The Contractor must notify EOHHS no later than sixty (60) days in advance of the proposed effective date of termination if the Contractor is choosing to terminate a Value-Added Service. Further, the Contractor must provide EOHHS with a plan to have all Members receiving the Value-Added Service complete their course of treatment at a clinically appropriate point and refer Members to an alternative service if medically appropriate and available under the benefit package.

b) The Contractor must notify the Choice Counselors no later than thirty (30) days in advance of the proposed effective date of termination.

c) The Contractor must notify all Members no later than thirty (30) days in advance of the proposed effective date of termination. The notification must be on the Member facing page of the Contractor's website as described in section 2.05.10 of this Agreement and in an updated version of all Member Materials. The Contractor should make a best effort to communicate directly with Members receiving the Value-Added Service."

19. **New Section 2.08.04.03 Contracting with EOHHS Certified Community Behavioral Health Clinics (CCBHCs),** is added.

20. **New Section 2.08.04.03.01 EOHHS Certifications of Certified Community Behavioral Health Clinics (CCBHCs),** is amended by ***ADDING*** the following:

"EOHHS is responsible for certifying CCBHCs. Certified CCBHCs are required to enter into contractual arrangements with EOHHS contracted managed care organizations. MCOs are contractually required to enter into arrangements with all EOHHS certified CCBHCs.

Contracts must be executed within ninety (90) days of a CCBHC being certified by EOHHS."

21. **New Section 2.08.04.03.02 Contracting/Network Adequacy,** is amended by ***ADDING*** the following: "The Contractor shall include in the health plan provider network, all CCBHCs certified by EOHHS."

22. **New Section 2.08.04.03.03 Operational, Quality, and Financial Reporting for CCBHC Initiative,** is amended by ***ADDING*** the following: "The Contractor will fully comply with the operational, quality, and financial reporting requirements as established by EOHHS for the CCBHC Initiative. The Contractor's submission of CCBHC-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)."

23. **New Section 2.09.12 Health Equity Strategies,** is amended by ***ADDING*** the following:

"EOHHS seeks to advance Health population health management strategies.

Strategies should be designed to promote equity, redress health disparities, and achieve optimal health outcomes for all Medicaid Members.

Achieving Health Equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and disparities.

The Contractor must participate in and support EOHHS's efforts to achieve Health Equity by reducing health disparities and social risk factors. The Contractor must develop and implement a Health Equity, Diversity and Inclusion Plan and strategy that complies with this Agreement.

The Contractor's Health Equity, Diversity and Inclusion Plan and strategy must:

a) Be developed in consultation with the Contractor's subcontracted AEs.

b) Reflect specific Member populations, communities, languages spoken and sociocultural dynamics.

c) Identify disparities in health care access, service provision, satisfaction and outcomes and the factors that drive those outcomes including social risk factors.

d) Prioritize the Health Equity outcomes that align with EOHHS' priorities and are most meaningful to the Contractor's Members.

e) Establish measurable targeted reductions for specified health disparities.

f) Identify programs, strategies and interventions to meet established targets to reduce disparities and address social risk factors.

g) Set near and long-term goals to incorporate Health Equity measures into the Contractor's value-based payment arrangements with its Subcontractors and Network Providers in accordance with guidance issued by EOHHS.

h) Solicit engagement and feedback from a representative group of Members to ensure that Contractor's Health Equity, Diversity and Inclusion Plan and strategy reflects the ethnic and cultural diversity of Members.

i) Identify and help coordinate community services and resources that can be offered to Members to address SDoH needs and demonstrate working relationships with community organizations to refer to and support provision of those service.

j) Identify how the Contractor, its Subcontractors and Network Providers will engage and support the State's broader Health Equity initiatives, including those involving sister agencies such as the Department of Health.

The Contractor's Health Equity, Diversity and Inclusion Plan and strategy must be submitted for review annually thereafter, and upon modification.

The Contractor must monitor progress toward implementing its Health Equity, Diversity and Inclusion Plan and strategy and must submit an annual report to EOHHS that include:

a) A narrative description of activities undertaken.

b) Quantitative progress toward meeting the measurable targets and goals identified in the plan and strategy."

24. **New Section 2.12.06 Chief Diversity, Equity, and Inclusion Officer,** is amended by ***ADDING*** the following two paragraphs:

"The Chief DEI Officer must report to the CEO or Director of Human Resources and is responsible for managing and overseeing the Contractor's efforts to:

a. Create a diverse and inclusive workforce.

b. Identify and address potential discrimination or biases in the workforce.

c. Ensure compliance with yearly workforce trainings, such as anti-bias, anti- racist, sexual harassment, and health inequities training.

d. Launch initiatives to change culture.

e. Create a supportive environment for underrepresented Members of the organization.

f. Develop, execute, and monitor compliance with a comprehensive, organization-wide Strategic Health Equity, Diversity and Inclusion Plan.

The Chief DEI Officer will serve as a leader in the organization and has primary responsibility for:

a. Submitting the Strategic Diversity and Inclusion Plan to EOHHS during Readiness Review, then annual reports describing Plan activities and outcomes.

b. Developing training programs for staff.

c. Reviewing and assessing the impact and effectiveness of diversity and inclusion programs."

25. **Section 2.13.02.02 Encounter Data Reporting – General Requirements,** is amended by ***INSERTING*** the following paragraph after the first paragraph of this section: "The Contractor will comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies, as amended or modified, in accordance with EOHHS policy."

26. **Section 2.15.04 Third-Party Liability,** is amended by ***DELETING*** the language in its entirety and ***REPLACING*** it with the following new language:

"Rhode Island Medicaid will be the payor of last resort for all Covered Services, unless otherwise required by federal laws or regulations.

Third-Party Liability ("TPL") refers to the legal obligation of any third-party entity or health insurance program, including health insurers, self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by law, contract, or agreement, responsible for payment of a claim for a Member's health care item or service.

Under Section 1902(a)(25) of the Social Security Act, EOHHS and the Contractor are 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 primary responsibility for identifying, collecting, and reporting TPL coverage and collection information to EOHHS on a weekly basis. As TPL information is a component of Capitation Rate development, The Contractor will maintain records regarding TPL collections and will report these collections to EOHHS in the timeframe and format determined by EOHHS, in accordance with Section 3.27.9, "Financial Data Reporting."

The projected amount of third-party recovery that the Contractor is expected to recover may be factored into the rate setting process.

The Contractor will designate one contact person for TPL matters.

The Contractor will develop and maintain a TPL Policy. The Contractor will submit the TPL Policy for EOHHS review and approval within ninety (90) Days of the execution of this Agreement. The Contractor must submit the TLP annually thereafter and upon EOHHS' request. In the event of modification of the TPL Policy, the Contractor will submit TPL Policy amendments to EOHHS for review and approval at least ninety (90) Days before the proposed effective date.

When the Contractor is aware of other insurance coverage prior to paying for a Covered Service for a Member, it should avoid payment by rejecting a provider's claim and direct the provider to submit the claim to the appropriate third party. The Contractor will follow exceptions to cost avoidance as outlined in 42 C.F.R. § 433.139.

The Contractor will collect and retain all TPL collections. The Contractor will document cost recovery and cost adjustment through the encounter data reporting process, including denials. All claims subject to "pay and chase" will be reported to EOHHS on a monthly

basis in accordance with Section 3.27.9, "Financial Data Reporting," and will include current recovery efforts.

The Contractor must obtain recovery of payment from a liable third party and not from the provider unless the provider received payment from both the Contractor and the liable third party.

The Contractor will have 365 Days from the original paid date to recover funds from the third-party entity. If funds have not been recovered by that date, EOHHS has the sole and exclusive right to pursue, collect and retain those funds.

The Contractor will 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.

EOHHS will review the effectiveness of the Contractor's TPL recovery programs annually and may revoke TPL activities from the Contractor if the recovery programs do not meet the effectiveness criteria defined by EOHHS in Managed Care Manual Chapter 5, "Financial Requirements"."

27. **Section 2.18.01 General Requirements** is amended by ***REVISING*** the 13th bullet as follows: "Provision for the notification to the State when it received information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor under 42 C.F.R. §438.608(a)(4) and 42 CFR §438.602 (b) (2)."

ARTICLE III: CONTRACT TERMS AND CONDITIONS

28. **Section 3.05.05 Subcontracts and Delegation of Duty**, is amended by ***REPLACING*** Paragraphs 3 and 4 to read as follows; "The Contractor shall monitor the performance of all subcontractors on an ongoing basis, consistent with industry standards and state and federal regulations. This includes conducting formal reviews based on a schedule established by EOHHS. Both the Contractor and subcontractor must take corrective action on any identified deficiencies or areas of improvement.

The Contractor is responsible for performance of the Agreement whether subcontractors are used. In compliance with 42 CFR.438.230(c) the Contractor must execute a written agreement with its subcontractors that specifies that Contractor's right to revoke the Agreement, outlining the reasons for the revocation of the contract, and specifies other remedies in instances where EOHHS or the Contractor determines the subcontractor has not performed satisfactorily."

ATTACHMENT N: SPECIAL TERMS AND CONDITIONS

29. This Attachment is amended by ***REPLACING*** the second paragraph of **Section 1. Definitions - 8. Medical Expenses** with the following: "Medical Expenses shall be the sum of paid claims, substantiated by encounter data, accrued medical expenses, and allowable general ledger claims as reported in the quarterly financial data cost report and summarized in the Risk Share Medical Expense exhibit, including the following:"

30. This Attachment is amended by ***ADDING*** the following to the end of the first paragraph of **Section 2. Risk Share/Gain Share Arrangement**: "… as reported in the quarterly financial data cost report and summarized in the Risk Share Medical Expense exhibit, inclusive of the adjustments noted earlier under Part 1."

31. This Attachment is amended by ***DELETING*** **Section 3. Monthly Risk Share/Gain Share Reporting**.

32. This Attachment is amended by ***REPLACING*** the first four (4) paragraphs of **Section 3. Risk Share/Gain Share Reconciliation and Payment/Recoupment** with the following: **"**At the end of the contract year, the Contractor shall submit its Q2 Financial Data Cost Report (FDCR) to EOHHS, reflecting premiums and claims with dates of service through June 30. EOHHS, in conjunction with its consulting actuary, will review the report and communicate any requisite follow-up questions to the health plan. Once the health plan has satisfactorily addressed these questions and effected any necessary adjustments to the Q2 FDCR, EOHHS will calculate the corresponding risk or gain share amount payable to or recoverable from the plan. This calculation will utilize Medical Expenses as summarized in the Risk Share Medical Expense exhibit in the Q2 FDCR and EOHHS' record of the premium rating group's membership and Baseline Medical. EOHHS will then pay or recoup 80% of the outstanding balance within sixty (60) days of receipt of satisfactory responses to follow-up questions regarding the Q2 FDCR.

    Final settlement of risk or gain share amount payable to or recoverable from the plan will be calculated after the twelve (12) month claims runout period and be based upon the Medical Expenses as summarized in the Risk Share Medical Expense exhibit in the subsequent year's Q2 FDCR. EOHHS, in conjunction with its consulting actuary, will review the report and communicate any requisite follow-up questions to the health plan. Additionally, EOHHS will request from the health plan records to substantiate non-encounterable Medical Expenses included in the final settlement. Records requested may include, but are not limited to, subsidiary ledgers, invoices, contracts, or other documents to substantiate reported pharmacy rebates, reinsurance premiums, recoveries, AE TCOC shared savings payments, TPL collections, and PPS settlement amounts.

    Once the health plan has satisfactorily addressed any questions and effected any necessary adjustments to the Q2 FDCR, EOHHS will calculate the corresponding risk or gain share amount payable to or recoverable from the plan. This calculation will utilize Medical Expenses as summarized in the Risk Share Medical Expense exhibit in the Q2 FDCR and EOHHS' record of the premium rating group's membership and Baseline Medical. EOHHS will pay or recoup the outstanding balance within sixty (60) days of receipt of satisfactory responses to follow-up questions regarding the Q2 FDCR."

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

33. The **Mental Health Parity** section is amended by ***RENAMING*** the section "**Mental Health Parity Requirements**" and ***REPLACING*** the existing text with the following: "The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA) requirements and establish coverage parity between Mental Health Benefits and Substance Use Disorder Benefits (collectively "Behavioral Health Benefits") and Medical/Surgical Benefits. The Contractor will cover Behavioral Health Benefits in a manner that is no more restrictive than the coverage for Medical/Surgical Benefits.

Attachment A, "Schedule of In-Plan Benefits" identifies the types and amount, duration, and scope of services and is consistent with EOHHS' parity analysis. The Contractor may cover additional services necessary to comply with the requirements for parity in Behavioral Health Benefits in 42 C.F.R. Part 438, Subpart K; however, the Contractor must provide advance written notice to and receive prior written approval from the EOHHS Managed Care Director when it believes this requirement is triggered.

The Contractor shall not:

a) Impose treatment limitations on Behavioral Health Benefits that are more restrictive than the predominant treatment limitations applied to substantially all Medical/Surgical Benefits.

b) Develop separate treatment limitations that only apply to Behavioral Health Benefits.

c) Use UR (Prior Authorization, retrospective reviews, etc.) or other medical management techniques for Behavioral Health Benefits that are not comparable to, or applied more stringently than, those applied Medical/Surgical Benefits. In accordance with 42 C.F.R. § 438.910, the Contractor's UR requirements must comply with parity requirements.

d) In accordance the Reporting Calendar, the Contractor shall submit reports documenting the number of Prior Authorization requests received for Behavioral Health Benefits and Medical/Surgical Benefits and the outcomes of these requests.

e) If EOHHS implements cost-sharing requirements or lifetime or annual benefit limits for managed care benefits, the Contractor shall comply with all applicable State and federal laws and regulations regarding parity as they relate to financial requirements, including the MHPAEA and 42 C.F.R. §§ 438.905 and 438.910.

The Contractor shall provide EOHHS with copies of all Non-Quantitative Treatment Limitations (NQTL) assessment tools, surveys, or corrective action plans related to compliance with MHPAEA.

The Contractor shall publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence.

The Contractor shall publish any processes, strategies, evidentiary standards, or other factors (collectively "factors") used in applying NQTL to Behavioral Health Benefits

on its website and in its Provider Manual and shall ensure the classifications are comparable to, and are applied no more stringently than, the factors used in applying the limitation for Medical/Surgical Benefits in the classification. The Contractor shall provide Behavioral Health Benefits in every classification in which it provides Medical/Surgical Benefits (e.g., inpatient, outpatient, emergency care, prescription drugs).

The Contractor shall ensure its NQTL for Behavioral Health Benefits will not be more restrictive, nor applied more stringently, than NQTL for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to Out-of-Network Providers of Behavioral Health Benefits that are comparable to and applied no more stringently than those used to determine access to Out-of-Network Providers of Medical/Surgical Benefits.

At EOHHS' request, the Contractor shall assist with claims reviews and audits regarding parity.

The Contractor shall provide EOHHS with its analysis ensuring parity compliance:

a) When new services are added as an In-Plan Benefits for Members; or

b) Prior to implementing changes to NQTL.

c) In the event of a suspected parity violation, the Contractor shall direct Members to its internal Complaint, Grievance, and Appeals process as appropriate. If the matter is not resolved to the Member's satisfaction through this process and forum, the Contractor shall instruct the Member that he or she may file an external medical review and/or a State Fair Hearing in accordance with their rights under Section 2.14.03, "Health Plan Grievance and Appeals Process."

The Contractor shall track and trend Complaints and Grievances related to parity in accordance with section 2.13.03, "Grievance and Appeals Data."

34. The **MENTAL HEALTH AND SUBSTANCE USE SERVICES** section is amended by ***INSERTING*** the following text after the first paragraph of the section: "**COURT ORDERED BEHAVIORAL HEALTH BENEFITS**"

"The Contractor shall provide Behavioral Health Benefits ordered by a Court with jurisdiction over behavioral health and SUD matters (e.g., drug, mental health, and family law courts), and services required by other state officials or bodies (e.g., probation officers, the Rhode Island State Parole Board) in accordance with applicable Rhode Island laws and regulations. The Contractor will not require Prior Authorization for such services, nor controvert their Medical Necessity in retrospective reviews.

The Contractor is required to cover court-ordered services provided by Out-of- Network Providers.

CARE COORDINATION AND DISCHARGE PLANNING

The Contractor shall require PCPs to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health or

SUD conditions or disorders. PCPs may provide any clinically appropriate behavioral health or SUD service within the scope of their practice.

The Contractor shall provide training to network PCPs on:

a) How to screen and identify behavioral health disorders.

b) The Contractor's referral processes for Behavioral Health Benefits.

c) The Contractor's clinical care coordination requirements.

The Contractor will educate behavioral health Providers on processes to refer Members with known or suspected and untreated physical health problems or disorders to their PCPs for examination and treatment.

The Contractor is responsible for developing operational processes with Providers to ensure they are aware when Members visit emergency departments or admitted to inpatient levels of care.

Prior to discharge from an inpatient psychiatric setting, all Members receiving inpatient psychiatric services must be scheduled for an outpatient follow-up visit with a mental health practitioner no later than seven (7) Days after discharge. In addition, Members who are clinically assessed in an ER setting and are not admitted to an inpatient LOC shall receive a follow up visit with a mental health practitioner within seven (7) Days of ER discharge. The Contractor may fulfill these requirements by either:

a) Contracting with Network hospitals or other Providers.

b) Using the Contractor's own or delegated Care Managers or Care Coordinators for outreach.

c) Contracting with another Care Coordination entity in the community.

The Contractor shall develop policies and procedures to ensure that discharge plans are shared with the Member's behavioral health provider, PCP, AE, or other care coordinating entity (as applicable) within three Business Days of discharge.

The Contractor shall work with hospital delivery systems to develop:

a) Transition of care protocols for Members discharged from the hospital, including clear documentation of each party's roles and responsibilities. The protocols will also address processes and procedures to coordinate with DCYF for children in DCYF care or custody.

b) Develop strategies to provide integrated and coordinated care to Members who may present with primary medical conditions who also have underlying behavioral health issues, such as alcohol or substance use related disorders, anxiety disorders, or mood disorders.

c) The Contractor's Network Provider Agreement with behavioral health Providers must require Providers to contact Members with missed appointments within twenty-four (24) hours to reschedule appointments."

ATTACHMENT P: BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

35. Section 3, **Mental Health Parity**, is amended by ***RENAMING*** the section "**Mental Health Parity Requirements**" and ***REPLACING*** the existing text with the following: "The Contractor shall fully comply with the Mental Health Parity Addiction Equity Act (MHPAEA) requirements and establish coverage parity between Mental Health Benefits and Substance Use Disorder Benefits (collectively "Behavioral Health Benefits") and Medical/Surgical Benefits. The Contractor shall cover Behavioral Health Benefits in a manner that is no more restrictive than the coverage for Medical/Surgical Benefits.

Attachment A, "Schedule of In-Plan Benefits" identifies the types and amount, duration, and scope of services and is consistent with EOHHS' parity analysis. The Contractor may cover additional services necessary to comply with the requirements for parity in Behavioral Health Benefits in 42 C.F.R. Part 438, Subpart K; however, the Contractor must provide advance written notice to and receive prior written approval from the EOHHS Managed Care Director when it believes this requirement is triggered.

The Contractor shall not:

a) Impose treatment limitations on Behavioral Health Benefits that are more restrictive than the predominant treatment limitations applied to substantially all Medical/Surgical Benefits.

b) Develop separate treatment limitations that only apply to Behavioral Health Benefits.

c) Use UR (Prior Authorization, retrospective reviews, etc.) or other medical management techniques for Behavioral Health Benefits that are not comparable to, or applied more stringently than, those applied Medical/Surgical Benefits. In accordance with 42 C.F.R. § 438.910, the Contractor's UR requirements must comply with parity requirements.

d) In accordance the Reporting Calendar, the Contractor shall submit reports documenting the number of Prior Authorization requests received for Behavioral Health Benefits and Medical/Surgical Benefits and the outcomes of these requests.

e) If EOHHS implements cost-sharing requirements or lifetime or annual benefit limits for managed care benefits, the Contractor must comply with all state and federal laws and regulations regarding parity as they relate to financial requirements, including the MHPAEA and 42 C.F.R. §§ 438.905 and 438.910.

The Contractor shall provide EOHHS with copies of all Non-Quantitative Treatment Limitations (NQTL) assessment tools, surveys, or corrective action plans related to compliance with MHPAEA.

The Contractor shall publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence.

The Contractor shall publish any processes, strategies, evidentiary standards, or other factors (collectively "factors") used in applying NQTL to Behavioral Health Benefits on its website and in its Provider Manual, and shall ensure the classifications are comparable to, and are applied no more stringently than, the factors used in applying the limitation for Medical/Surgical Benefits in the classification. The Contractor shall provide Behavioral Health Benefits in every classification in which it provides Medical/Surgical Benefits (e.g., inpatient, outpatient, emergency care, prescription drugs).

The Contractor shall ensure its NQTL for Behavioral Health Benefits will not be more restrictive, nor applied more stringently, than NQTL for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

The Contractor shall implement and use processes, strategies, evidentiary standards, or other factors in determining access to Out-of-Network Providers of Behavioral Health Benefits that are comparable to and applied no more stringently than those used to determine access to Out-of-Network Providers of Medical/Surgical Benefits.

At EOHHS' request, the Contractor shall assist with claims reviews and audits regarding parity.

The Contractor will provide EOHHS with its analysis ensuring parity compliance:

a) When new services are added as an In-Plan Benefits for Members; or

b) Prior to implementing changes to NQTL.

c) In the event of a suspected parity violation, the Contractor shall direct Members to its internal Complaint, Grievance, and Appeals process as appropriate. If the matter is not resolved to the Member's satisfaction through this process and forum, the Contractor shall instruct the Member that he or she may file an external medical review and/or a State Fair Hearing in accordance with their rights under Section 2.14.03, "Health Plan Grievance and Appeals Process."

The Contractor shall track and trend Complaints and Grievances related to parity in accordance with section 2.13.03, "Grievance and Appeals Data."

36. **New Section 4. Court Ordered Behavioral Health Benefits,** is amended by ***ADDING*** the following: "The Contractor must provide Behavioral Health Benefits ordered by a Court with jurisdiction over behavioral health and SUD matters (e.g., drug, mental health, and family law courts), and services required by other state officials or bodies (e.g., probation officers, the Rhode Island State Parole Board) in accordance with applicable Rhode Island laws and regulations. The Contractor will not require Prior Authorization for such services, nor controvert their Medical Necessity in retrospective reviews.

The Contractor shall cover court-ordered services provided by Out-of- Network Providers."

37. **New Section 5. Care Coordination and Discharge Planning,** is amended by ***ADDING*** the following: "The Contractor shall require PCPs to have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected

behavioral health or SUD conditions or disorders. PCPs may provide any clinically appropriate behavioral health or SUD service within the scope of their practice.

The Contractor shall provide training to network PCPs on:

a) How to screen and identify behavioral health disorders.

b) The Contractor's referral processes for Behavioral Health Benefits.

c) The Contractor's clinical care coordination requirements.

The Contractor shall educate behavioral health Providers on processes to refer Members with known or suspected and untreated physical health problems or disorders to their PCPs for examination and treatment.

The Contractor shall develop operational processes with Providers to ensure that they are informed and aware of when Members visit emergency departments or are admitted to inpatient levels of care.

Prior to discharge from an inpatient psychiatric setting, all Members receiving inpatient psychiatric services shall be scheduled for an outpatient follow-up visit with a mental health practitioner no later than seven (7) Days after discharge. In addition, Members who are clinically assessed in an ER setting and are not admitted to an inpatient LOC must receive a follow up visit with a mental health practitioner within seven (7) Days of ER discharge. The Contractor may fulfill these requirements by either:

a) Contracting with Network hospitals or other Providers; or,

b) Using the Contractor's own or delegated Care Managers or Care Coordinators for outreach; or,

c) Contracting with another Care Coordination entity in the community.

The Contractor shall develop policies and procedures to ensure discharge plans are shared with the Member's behavioral health provider, PCP, AE, or other care coordinating entity (as applicable) within three (3) Business Days of discharge.

The Contractor shall work with hospital delivery systems to develop:

a) Transition of care protocols for Members discharged from the hospital, including clear documentation of each party's roles and responsibilities. The protocols will also address processes and procedures to coordinate with DCYF for children in DCYF care or custody.

b) Strategies to provide integrated and coordinated care to Members who may present with primary medical conditions who also have underlying behavioral health issues, such as alcohol or substance use related disorders, anxiety disorders, or mood disorders.

c) Requirements in the Contractor's Network Provider Agreement with behavioral health Providers mandating that Providers contact Members with missed appointments within twenty-four (24) hours to reschedule appointments."

38. **Section C. Long Term Residential Programs** is amended by ***INSERTING*** a new heading **C. Enhanced Mental Health Psychiatric Rehabilitative Residences (E-MHPRR)** and ***ADDING*** the following: "The Contractor is required to contract with and support E-MHPRRs which provide services for patients with complex mental health needs that are being discharged from hospital settings and require enhanced services in a community setting. Individuals requiring these enhanced services include those with a dual diagnosis of behavioral health and developmental disabilities, cooccurring disorders (mental health disorder and substance use disorder), comorbidities (behavioral health disorder and significant medical conditions), those who have suffered a traumatic brain injury (TBI) with a dual mental health related diagnosis, persons who have exhibited serious self-injurious behaviors or violence against others; those who have been convicted of sexual offenses or who exhibit sex offender behaviors, and fire starters. There are three (3) categories of E-MHPRRs are:

    1. Medically Intensive MHPRR: Individuals diagnosed with mental illness and complex medical conditions, requiring increased medical monitoring, personal care assistance, and specialized environmental modifications.
    2. Intensive Behavioral MHPRR: Provides increased therapeutic interventions and supervision. Including one-to-one support on a consistent basis that focuses on identifying triggers and precipitant behaviors, coping skills, improving communication skills, addressing issues around substance use, and identifying and resolving barriers to the traditional MHPRR setting. Other individuals appropriate for this service are those with non-acute suicidality with a high risk of self-harm who have been determined to no longer be appropriate for an inpatient setting.
    3. Intensive Forensic Supportive MHPRR: Individuals who are no longer clinically severely symptomatic but must be provided with a highly structured and secure environment for prolonged periods of time awaiting the resolution of criminal proceedings.

       Intensive Behavioral and Forensic MHPRRs have two (2) subspeciality treatment groups:

        a) Intensive Fire Safety MHPRR: Provides enhanced supervision and monitoring for fire setting behavior, therapeutic interventions to address individually identified risk behaviors, and a physical setting to minimize the risk of fire.
        b) Sex Offender MHPRR: Provides a safe and therapeutic environment for individuals who have been convicted of a sexual offense and/or are at risk for offending.

    Only community residences licensed by Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities & Hospitals that are in good standing and in compliance with the MHPRR rules and regulations detailed in 210 RICR-10-10-1.6.12, and state and federal regulations are eligible to be an E-MHPRR. E-MHPRR must also adhere to additional Certification Standards which further detail staff expectations, client services offered, and required state reporting. E-MHPRRS will have no more than nine client per facility."

ATTACHMENT Q: CARE MANAGEMENT PROTOCOLS FOR ALL MEMBERS

39. **Section 3.07.03** is amended by adding ***INSERTING*** the following section:

"Provisions for Members who are eligible for the Katie Beckett Waiver
Purpose:

To ensure that Members eligible for, or who may in the future receive, HBTS/ABA services under the Katie Beckett Waiver (KBW) receive adequate and appropriate services and supports, including access to multiple Provider Agencies, in the most integrated setting appropriate for their needs, consistent with the requirements of the ADA and it's implementing regulations.

Services:
The Contractor will provide all eligible members with the following services:

- Individualized assessment of concerns and needs with family and child, as further detailed in section A, below;
- Person-centered planning;
- Family care plan development that includes a "crisis support care plan" as necessary, as further detailed in section B, below;
    - A "crisis support care plan" details individuals or agencies (e.g., child's Primary Care Physician (PCP), local mental health center) for the family to contact in the event of a specific crisis and actions to take to ensure the safety of the child and family, as further detailed in section C, below.
- Care coordination and assistance in accessing services, including multiple provider care coordination if it is determined that more than one provider is required to provide services, as further detailed in section D, below;
- Support during transitions through levels of care; and entry into the adult service of care.

In addition to the above identified services, the Contractor shall support Members by serving as a conflict free independent agency that shall:

- designate a Case Manager
- implement the multiple provider policy *(HBTS/ABA Certification Standards addendum, June 8, 2021*;
- advocate and assist in ensuring that a beneficiary and family's service needs are met;
- serve as the coordinator/manager of services to facilitate and coordinate services when families need to access home-based community services;
- navigate the Medicaid children's services system; and
- provide oversight of service delivery to Members and their families to ensure accountability and delivery of medically necessary covered services.

EOHHS directs the Contractor that more than one (1) Provider Agency may be used to receive necessary services if the initial provider is unable to fully deliver the medically necessary services identified in a member's individualized service plan.

The State shall clarify current practice and procedures with EOHHS staff, Contractor, Provider Agencies, and Members to ensure appropriate access to services from multiple Provider Agencies as written policy is being finalized and implemented.
Every Member shall be assigned to a Case Manager who will work with Provider Agencies for the delivery of medically necessary community-based services and/or supports.

- The Case Manager conducts care coordination to ensure that Members receive all medically necessary community-based services and/or supports.
- The Case Manager will work with certified Provider Agencies to facilitate the delivery of all medically necessary community-based services and/or supports.
- If a Provider Agency cannot meet a Member's needs as determined by the Case Manager and EOHHS, the Case Manager and EOHHS shall convene a meeting with the family in order to determine additional community-based services and/or supports or to transition services to another certified Provider Agency if the family desires a change in providers.

The Contractor shall provide Members, Members' families, or responsible representatives of Members with the EOHHS Ombudsman e-mail and phone number to contact in the event that they have any concerns about the services received.
Provider Agencies and Contractor shall provide the informational materials described above and the Ombudsman e-mail and phone number to Members at the development of the Member's support plan.

Needs Assessment

The Contractor shall ensure that a face-to face meeting between the family and Case Manager occurs to determine the current needs of the child and family. The Assessment must be completed within forty-five (45) calendar days of initial request, or sooner, based upon the urgency of the child and family's needs. The family and the Case Manager shall determine the most effective way to address their immediate concerns. Every effort shall be made to include or have the child present during a portion of the visit.
It is expected that the level of information gathered is sufficient to develop a plan to address the current and unique needs of each child and family and be related to the level of assistance requested by the family from the Contractor. If the child or family's needs change at any time during their engagement with the Contractor, additional information can be obtained as needed.
The Needs Assessment process shall include the following considerations:

- Presenting concern(s)/need(s)
- Current interventions/involvements
- Approaches/strategies tried or considered
- Formal and informal resources
- Barriers or limitations
- Other relevant information
- Need for crisis planning

It is expected that the Case Manager will gather sufficient information during the Needs Assessment to complete a determination of the needs of the child and family and to develop a plan to address these needs. Additional information may be needed to make a

determination about the efficacy of identified referrals. In these instances, the Case Manager shall identify this as an action step in the Family Care Plan.

Family Care Plan

The initial Family Care Plan must be completed within forty-five (45) calendar days from the referral. Family Care Plans shall be reviewed with the family and updated as needed. The Family Care Plan shall be developed with and signed by the child's parent(s) or authorized guardian(s) as an agreement to work towards the action plan as indicated. A Family Care Plan must be reviewed and signed by an independently licensed clinician and may be in place for up to twelve (12) months.

General principles for the Care Plan include, but are not limited to:

- Plans shall be individualized, detailed, flexibly designed and developed within the family's cultural and community context.
- Functional and measurable outcomes meaningful to the family shall be the basis of every Family Care Plan. The Family Care Plan must include:
    - Action Steps to address the identified needs of the child.
    - Timelines for Completion.
    - Identification of the Party responsible for carrying out the Action Step; and the
    - Date that the Action Step is achieved.
- The Family Care Plan shall be developed with the family and in coordination with existing community resources.
- The Family Care Plan is based on assessment information, on the strengths and needs of the child and family. Support shall be targeted to occur in the most natural environment and in the least restrictive setting appropriate.
- The Family Care Plan should identify both natural and formal supports needed and incorporate services and supports designed to meet all.
- Where formal supports are involved, attention should be given toward building on the strengths of the child, family, extended family and community supports to support long-term empowerment.

Crisis Support Plan

Recognizing that families may experience a crisis that requires immediate support, Contractor shall authorize Case Managers to assist the family in planning for potential crises and for linking them to supports and services in a timely manner. Crises include medical emergencies, behavioral health crises, food or housing problems, service delivery issues (provider coverage), etc. An important component of the assessment and care plan process is the development of a Crisis Support Plan as part of Crisis Intervention Support. The Crisis Support Plan should be completed as needed and a copy of the plan left with the family.

If needed, the Case Manager shall work with the family to develop an individualized Crisis Support Plan which includes individuals or agencies for the family to contact in the event of a specific crisis (e.g., child's Primary Care Physician (PCP), local mental health center) and actions to take to ensure the safety of the child and family.

The Crisis Support Plan should be reviewed and updated as needed. The Contractor and Case Manager are not expected to be a direct provider of crisis intervention services; rather

they are responsible for assisting the family in identifying providers to call in the event of a specific crisis or emergency. However, the Contractor and Case Manager must be able to provide crisis follow-up and care coordination for those instances when the family is open to the Case Manager When notified of the crisis, the Case Manager, within one (1) business day, shall offer direct follow-up communication with clinical staff of the direct service provider of crisis intervention services, collaboratively work with the family in determining next steps, and arrange for community-based services as appropriate. This crisis follow-up coordination must directly involve and be closely overseen by a licensed clinician although additional staff of the Contractor may be involved.

Care Coordination

Care Coordination shall be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills in order for families to increase their independence in obtaining and accessing services. This includes:

- Provide and assist families in obtaining information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of covered services , such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, insurance plans, school-based services, faith based organizations, etc.
- Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider and payer. This also includes follow-up and consultation with the evaluator as needed.
- Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure engagement of services and supports.

Active Contract Management Specifics:

The Contractor shall meet with EOHHS on a monthly basis to review the following:

- Performance
- utilization of services
- compliance
- quality assurance, and
- continuous quality improvement.

The State will develop an Active Contract Management (ACM) process by which program oversight will be conducted through quarterly meetings with the Contractor to review key performance indicators (KPIs) and deliverables and other metrics that may be identified by EOHHS on a quarterly basis. Deliverables will include monitoring that Members receive staffing for all authorized services that the Member's family agrees to receive, and actions taken if the deliverable has not been achieved.

Reporting/Deliverables

- Monitoring that Members receive staffing for all authorized services that the

    - Member's family agrees to receive, and actions taken if the deliverable has not been achieved. The ACM process will include a monthly review of each MCO.
- EOHHS shall engage the MCOs in the Active Contract
    - Management (ACM) process by applying high-frequency use of data and purposeful management of agency-service provider interactions to improve services and deliverables.
    - Additional Deliverables shall include:
        - data related to family care plan goals being met,
        - family care plan coordination,
        - annual family satisfaction surveys and complaints and resolutions."

ATTACHMENT V: COVID 19 PUBLIC HEALTH EMERGENCY

40. **Attachment V** is amended by ***DELETING*** the language in its entirety and ***REPLACING*** it with the following new language: "Contractor shall follow EOHHS policies related to the coverage at the declaration of the end of the Public Health Emergency (PHE). Such policies include access and treatment related to the supporting of EOHHS' efforts to ensure access to testing, treatment and other flexibilities and authorities provided during the PHE by CMS and EOHHS. Such decisions will be at the discretion of EOHHS."

IN WITNESS HERETO, the parties have caused this Amendment 10 to the 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:

Kristin Pono Sousa Digitally signed by Kristin Pono Sousa Date: 2023.06.15 10:33:19 -04'00'

SIGNATURE

Kristin Pono Sousa

NAME

Medicaid Program Director

TITLE

6/15/23

DATE

TUFTS HEALTH PUBLIC PLANS:

DocuSigned by:
Phil Barr
5A0CBFF20347F...

SIGNATURE

Phil Barr

NAME

President, Markets

TITLE

5/25/2023

DATE