This Contract, made on July 1, 2022 is hereby restated and amended effective July 1, 2023, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), The State of Rhode Island, acting by and through the Executive Office of Health and Human Services (RI EOHHS), and Neighborhood Health Plan of Rhode Island (Contractor). Contractor's principal place of business is 910 Douglas Pike, Smithfield, RI 02917.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XI, Title XVIII, Title XIX, and Title XXI of the Social Security Act; WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, RI EOHHS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the RI 1115(a) Comprehensive Demonstration, designed to pay for medical, behavioral health, and Long Term Services and Supports (LTSS) for Eligible Beneficiaries (Enrollee, or Enrollees); WHEREAS, Contractor is in the business of arranging medical services, and CMS and RI EOHHS desire to purchase such services from Contractor;

WHEREAS, Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations; WHEREAS, the goal of the Phase II of the Integrated Care Initiative (ICI) is to improve the health, well-being, and health care of Medicare-Medicaid beneficiaries in Rhode Island and to reduce overall health care costs by redesigning the care delivery system.

WHEREAS, through an integrated financing mechanism, Contractor agrees to provide an integrated service delivery model that promotes the use of alternative payment models, eliminates fragmentation in care delivery, improves coordination of services, promotes community-based care over institutional care, and provides access to high quality, cost-effective person-centered services and supports.

WHEREAS, the essential elements of the ICI Phase II care delivery model include: a comprehensive continuum of high-quality services that are easily accessible, effectively coordinated, delivered in the least restrictive setting, and funded through a single capitated financing structure in a Medicare-Medicaid managed care organization; the transition to value-based over volume-based purchasing, through specified contracting targets for the Medicare-Medicaid managed care organization; integration of medical, behavioral health, LTSS, and social services; and an interdisciplinary care management model that effectively leverages existing care management and care coordination services available to Enrollees and is integrated with the care and services delivered by Enrollee's providers;

WHEREAS, CMS and EOHHS seek to extend this Contract through December 31, 2025;

WHEREAS, in accordance with Section 5.7.1 of the Contract, EOHHS and the Contractor desire to amend the Contract;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

1. This Addendum deletes **Subsection 2.6.2.4.4.** adds a new **Subsection 2.6.2.4.4.**

2.6.2.4.4.1	For all Enrollees described above in Sections 2.6.2.4.3.1 through 2.6.2.4.3.2.2, the Contractor will further be required to ensure an in-person re-assessment within fifteen (15) Days of identifying a significant change in the Enrollee's condition or needs or the circumstances described in Section 2.6.2.4.8, with the exception of hospitalizations. Following a hospitalization, telephonic outreach to the Enrollee will be conducted within five (5) Days of discharge. A re-assessment will be completed within fifteen (15) Days of discharge. A re-assessment following a hospitalization is not required for Enrollees described below in Section 2.6.12.

2. This Addendum adds a new **Section 3.5**:

3.5. Demonstration Transition (Phase-Out)

3.5.1. For purposes of meeting the Demonstration phase-out requirements set forth in Section III.L.4 of the MOU, EOHHS and CMS agree that a phase-out plan does not need to be published on the EOHHS website for public comment if the following conditions are met:

3.5.1.1. Ongoing stakeholder engagement;

3.5.1.2. Public comment related to any new or amended Medicaid waivers associated with the Demonstration;

3.5.1.3. Stakeholder engagement and beneficiary testing of notifications of Enrollee coverage decisions related to the Demonstration ending; and

3.5.1.4. Ongoing collaboration and planning with CMS to ensure Enrollees will be successfully enrolled in a Part D plan upon termination of the Demonstration.

3. This Addendum deletes **Subsection 4.1.2.1** and replaces it with the following **Subsection 4.1.2.1**:

4.1.2.1. Capitation Rate updates will take place as on January 1st of each calendar year for the Medicare rate component and on a State Fiscal Year (SFY) basis for the Medicaid rate component, or more frequently, as described in this section; however, savings percentages (see Section 4.2.3) and quality withhold percentages (see Section 4.4.7) will be applied based on final Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	July 1, 2016 – December 31, 2017
2	January 1, 2018 – December 31, 2018
3	January 1, 2019 – December 31, 2019
4	January 1, 2020 – December 31, 2020
5	January 1, 2021 – December 31, 2021
6	January 1, 2022 – December 31, 2022
7	January 1, 2023 – December 31, 2023
8	January 1, 2024 – December 31, 2024
9	January 1, 2025 – December 31, 2025

4. This Addendum deletes **Subsection 4.2.3.1** and replaces it with the following **Subsection 4.2.3.1**:

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.4.5.7.

4.2.3.1.1. Demonstration Year 1: 1%

4.2.3.1.2. Demonstration Year 2: 1.25%

4.2.3.1.3. Demonstration Year 3: 3%

4.2.3.1.4. Demonstration Year 4: 3%

4.2.3.1.5. Demonstration Year 5: 3%

4.2.3.1.6. Demonstration Year 6: 3%

4.2.3.1.7. Demonstration Year 7: 3%

4.2.3.1.8. Demonstration Year 8: 3%

4.2.3.1.9. Demonstration Year 9: 3%

5. This Addendum deletes and replaces Subsections 4.3.2.1 and 4.3.2.2 as follows:

4.3.2.1 The Contractor has a minimum target medical loss ratio (MLR) of eighty-five percent (85%) for Demonstration Years 1 through 4, eighty-six percent (86%) for Demonstration Year 5, eighty-seven percent (87%) for Demonstration Year 6, and eighty-eight (88%) percent for Demonstration Year 7, Demonstration Year 8, and Demonstration Year 9.

4.3.2.2 If the MLR calculated as set forth below is less than the minimum target MLR, the Contractor shall refund to RI EOHHS and CMS an amount equal to the difference between the calculated MLR and the minimum target MLR (expressed as a percentage) multiplied by the coverage year revenue, as described below. RI EOHHS and CMS shall calculate an aggregate MLR for Enrollees under this Contract, and shall provide to the Contractor the amount to be refunded, if any, to RI EOHHS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and RI EOHHS, separately, any amount to be refunded may be recovered either by requiring the Contractor to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, RI EOHHS and CMS may adopt NAIC reporting standards and protocols after giving written notice to the Contractor.

4.3.2.2.1 For Demonstration Years 2 through 4, if the Contractor has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the Contractor, the Contractor must remit the amount by which the eighty-five (85%) threshold exceeds the Contractor's actual MLR multiplied by the total Capitation Payment revenue of the contract.

4.3.2.2.2. For Demonstration Years 5 through 9, in addition to remitting the amount by which the eighty-five percent (85%) threshold exceeds the Contractor's MLR multiplied by the total Capitation Payment revenue, the Contractor will also remit according to the following schedule:

4.3.2.2.2.1. In Demonstration Year 5, if the Contractor's MLR is below eighty-six percent (86%), the Contractor will remit fifty percent (50%) of the difference between its MLR and eighty-six percent (86%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is above 85%) or 0.5% multiplied by the total Capitation Payment revenue (if the Contractor's MLR is at or below 85%);

4.3.2.2.2.2. In Demonstration Year 6, if the Contractor's MLR is below eighty-seven percent (87%), the Contractor will remit fifty percent (50%) of the difference between its MLR and eighty-seven percent (87%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is above 85%) or 1.0% multiplied by the total Capitation Payment revenue (if the Contractor's MLR is at or below 85%);

4.3.2.2.3. In Demonstration Years 7 through 9, if the Contractor's MLR is below eighty-eight percent (88%), the Contractor will remit fifty percent (50%) of the difference between its MLR and eighty-eight percent (88%) multiplied by the total Capitation Payment revenue (if the Contractor's MLR is above 85%) or 1.5% multiplied by the total Capitation Payment revenue (if the Contractor's MLR is at or below 85%).

4.3.2.2.4. Exhibit 1B below identifies the remittance percentages by year for a sample MLR of eighty-seven percent (87%).

Exhibit 1B MLR Remittance Percentages Years 5-9, Sample MLR of 87%

Year	Actual Contractor MLR	Remittance Percentage*
Demonstration Year 5	87%	0%
Demonstration Year 6	87%	0%
Demonstration Year 7	87%	0.5%
Demonstration Year 8	87%	0.5%
Demonstration Year 9	87%	0.5%

*Total remittance equal to remittance percentage multiplied by total Capitation Payment Revenue

6. This Addendum deletes and replaces **Subsection 4.4.7.6** and replaces it with the following **Subsection 4.4.7.6**:

4.4.7.6 Quality Withhold Percentages

4.4.7.6.1 Aggregate quality withhold percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate:

4.4.7.6.1.1 Demonstration Year 1: 1.0%

4.4.7.6.1.2 Demonstration Year 2: 2.0%

4.4.7.6.1.3 Demonstration Year 3: 3.0%

4.4.7.6.1.4 Demonstration Year 4: 3.0%

4.4.7.6.1.5 Demonstration Year 5: 4.0%

4.4.7.6.1.6 Demonstration Year 6: 4.0%

4.4.7.6.1.7 Demonstration Year 7: 4.0%

4.4.7.6.1.8 Demonstration Year 8: 4.0%

4.4.7.6.1.9 Demonstration Year 9: 4.0%

7. This Addendum deletes and replaces **Subsection 4.4.7.8** and replaces it with the following **Subsection 4.4.7.8**:

4.4.7.8 Withhold Measures in Demonstration Years 2-9

4.4.7.8.1 Exhibit 3 below identifies the withhold measures for Demonstration Years 2 through 9. Together, these will be utilized as the basis the withhold amounts defined in Sections 4.4.7.6.1.2 through 4.4.7.6.1.9.

4.4.7.8.2 Payment will be based on performance on the quality withhold measures listed in Exhibit 3 below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.4.7.8.3 If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Exhibit 3 for a given year due to low Enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes.

Exhibit 3 Quality Withhold Measures for Demonstration Years 2-9

Measure	Source	CMS Core Withhold Measure	State Withhold Measure
Customer Service (DY 2 only)	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly (DY 2 only)	AHRQ/CAHPS	X	
Annual Flu Vaccine	CAHPS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Encounter Data	CMS-defined Process Measure	X	
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	PQA/PDE data	X	
Plan All-Cause Hospital Readmissions	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Care for Older Adults – Medication Review	NCQA/HEDIS		X
Care for Older Adults – Functional Status Assessment	NCQA/HEDIS		X
Care for Older Adults – Pain Assessment (DY 2 through 8 only)	NCQA/HEDIS		X
Care for Older Adults – Advance Care Planning (DY 2 – 5 only)	NCQA/HEDIS		X
LTC Nursing Facility Diversion (DY 2 – 4 only)	State-defined Measure/AARP LTSS Scorecard		X
SNF Discharges to the Community	State-define Measure/AHCA		X
SNF Hospital Admissions	State-defined Measure/AHCA		X
Rhode to Home Eligibility (DY 2 Only)	State-defined Measure		X

Measure	Source	CMS Core Withhold Measure	State Withhold Measure
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	NCQA/HEDIS		X
Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers	State-defined Measure/MDS Data		X
Long-Stay Nursing Facility Residents who Received Antipsychotic Medications (DY 2 – 4 only)	State-defined Measure/MDS Data		X

8. This Addendum replace **Subsection 5.9.1** with the following **Subsection 5.9.1**:

5.9.1 Contract Effective Date

5.9.1.1 This Contract shall be in effect through December 31, 2025 and, so long as the Contractor has not provided CMS with a notice of intention not to renew, and CMS/RI EOHHS have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506, shall be renewed in one-year terms, through December 31, 2025.

5.9.1.2 This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2025. The Contract shall be renewed in one-year terms through December 31, 2025, so long as the Contractor has not provided CMS and RI EOHHS with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5, above.

5.9.1.3 Rhode Island may not expend federal funds for, or award federal funds to, the Contractor until Rhode Island has received all necessary approvals from CMS. Rhode Island may not make payments to Contractor by using federal funds, or draw federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by Contractor prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

9. This Addendum amends Appendix A with the following changes:

a. "Doula Services" is added as a covered service with the following Scope of Work description:
    i. Prenatal and post-partum care is covered for pregnant woman and new mothers. Services include but not limited to services that support pregnant members, improve birth outcomes, and support new mothers; advocating for and supporting breastfeeding and infant care; provide resources, education, care, and emotional support for the member after pregnancy ends; and support for the member and family during the post-partum recovery. The plan will pay for six (6) visits per pregnancy for prenatal and post-partum care and one (1) labor and delivery visit.
b. "Respite" as a Preventive Service is deleted.

10. This Addendum amends Appendix L with the following additional waivers:

L3. Section 1851(h), Section 1852(c), and Section 1860 D-4 of the Social Security Act and the implementing regulations at 42 C.F.R. 422 and 423, Subparts C and V, only insofar as such provisions are inconsistent with the Marketing Guidance for Rhode Island Medicare-Medicaid Plans developed for the Demonstration.

L4. Section 1857 (c) and (d) of the Social Security Act and the implementing regulations at 42 C.F.R. §§ 422.506(a)(2)(ii), 422.2267(e)(1), 422.2267(e)(3), 422.2267(e)(10) insofar as such provisions are inconsistent with communicating with beneficiaries earlier than 90 days until the end of the Demonstration, and tailoring the beneficiary communications to include alternative enrollment options that provide integrated care as well as allowing the affiliated D-SNPs to utilize a customized Annual Notice of Change and Evidence of Coverage for the transition of members from Contractor to D-SNPs.

L5. Section 1851(c) of the Social Security Act and the implementing regulations at 42 C.F.R. § 422.60(g) insofar as such provisions are inconsistent with transitioning Contractor beneficiaries into an affiliated dual special needs plan at the end of the Demonstration.

In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Peter M. Marino

Peter Marino

Chief Executive Officer

Neighborhood Health Plan of Rhode Island

6/26/2023

Date

Reviewed by
Legal - ME

In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Lindsay P. Barnette — 7/5/2023

Lindsay P. Barnette — Date

Director

Models, Demonstrations, and Analysis Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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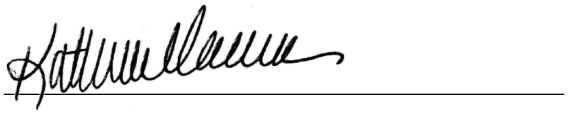
In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:



06/21/2023

Kathryn A. Coleman — Date

Director

Medicare Drug & Health Plan Contract Administration Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

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In Witness Whereof, CMS, RI EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Kristin Pono Sousa

Kristin Pono Sousa

Medicaid Program Director

Executive Office of Health and Human Services

6/29/2023

Date

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