NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

AMENDMENT NO. 21

THIS AGREEMENT, AMENDMENT NO. 21 is made and entered into on July 1, 2026, 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 Neighborhood Health Plan of Rhode Island (hereinafter referred to as "Contractor").

WHEREAS, EOHHS and Contractor entered into a Contract Between the State of Rhode Island Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services (hereinafter referred to as "Agreement") dated March 1, 2017.

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. 21.

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

ARTICLE II: HEALTH PLAN PROGRAM STANDARDS

1. Section 2.05.10.01 Required Information is amended by ***INSERTING*** "Inclusion of EPSDT beneficiary rights" to the bulleted list.

2. Section 2.06.01.03 Pharmacy Services is amended by ***DELETING*** the second paragraph and inserting the following:

"**Cell and Gene Therapy Access Model for Sickle Cell Disease**

All high-cost model drugs for the Sickle Cell Disease (SCD) Cell and Gene Therapy (CGT) Access Model must be paid for outside of any inpatient payment bundles at Actual Acquisition Cost (AAC) and in a manner such that rebates under the Medicaid Drug Rebate Program (MDRP) apply. The state shall be the receiver of all federal and supplemental rebates associated with CGT Access model drugs. MCOs are prohibited from collecting rebates on model drugs.

Managed Care Organization, (MCOs) must adhere to EOHHS guidance and ensure that beneficiary access policies and reimbursement methodologies align with Fee for Service policies. The contractor will submit any requested data, utilization reports, financials or other requested or relevant information to EOHHS in the form it is requested and at a cadence defined by the state. The State reserves the right to revise the administrative, clinical, or other applicable requirements and guidance if deemed necessary by the State or CMS.

High-Cost Drug Carve Out

High-cost drugs shall be:

- Listed on the EOHHS website
- Carved out of capitation rates
- Reimbursed at Fee for Service (FFS) rates by the MCO via a pass-through mechanism

- Excluded from risk arrangements with the MCO as the state will subsequently reimburse the FFS costs at a cadence defined by the state that is actuarily sound

The MCOs remain responsible for:

- Prior Authorization - using criteria developed by or approved by the state
- Care Coordination – continuing to manage access to appropriate care, and to case manage as needed
- Reporting- providing any requested data to the state
- Claims adjudication – adjudicating claims in a timely manner defined by the State and submit reconciliation materials to the state to seek reimbursement

The State retains the right to:

- Conduct audits as necessary
- Modify the structure or cadence of the pass-through model as deemed necessary by the state
- Seek supplemental materials as needed to ensure compliance"

3. Section 2.08.01 Network Composition is amended by ***ADDING*** the following bullet point to the final list of this section:

"Each individual or group provider must meet Rhode Island Medicaid's location and physical presence requirements, as well as the telehealth requirements. [210-RICR-20-00-1]"

4. Section 2.15.01.01 Fee Schedule Increase, Adoption of a Minimum/Maximum Fee Schedule and State Directed Payment Requirements is amended by ***UPDATING*** the following rows in the State Directed Payments table, as shown in the table found in *Exhibit A*.

5. Section 2.18 Compliance is amended by ***DELETING*** it in its entirety and ***REPLACING*** with new **Section 2.18 Compliance**, as shown in *Exhibit B*, attached hereto.

6. New Section 2.19 Program Integrity is ***INSERTED,*** as shown in *Exhibit C*, attached hereto.

ARTICLE III: CONTRACT TERMS AND CONDITIONS

7. Section 3.01.04 Effective Date and Term is amended by ***UPDATING*** the first paragraph as follows:

"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 is for five (5) years under the terms herein for the period March 1, 2017 to June 30, 2022 with *seven (7)* 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.

8. Section 3.07.03 Fraud and Abuse is ***DELETED*** in its entirety.

ATTACHMENTS

9. Attachment A: Schedule of In-Plan Benefits is amended by ***DELETING*** the Scope of Benefit description for "Doula Services" and ***REPLACING*** with the following:

"Covered for all Medicaid members when medically necessary and includes prenatal visits, labor and delivery supports, and post-partum visits. Doula Services are covered regardless of the outcome of the pregnancy."

10. Attachment H: Contractor's Capitation Rates SFY 2026 is amended by ***RENAMING*** the attachment to: "Contractor's Capitation Rates SFY 2027"

11. Attachment H: Contractor's Capitation Rates SFY 2026 is further amended by ***DELETING*** the text in its entirety and ***REPLACING*** it with the following:

"Please see the attached Rate Book and Tables:

State Fiscal Year 2027 Risk Adjustment Medicaid Managed Care Program, dated April 24, 2026." As shown in *Exhibits D and E*, attached hereto.

12. Attachment I: Rate-Setting Process is amended by ***DELETING*** the text in its entirety and ***REPLACING*** it with the following:

"Please see the attached Rate Books and attachments:

State Fiscal Year 2027 Medicaid Managed Care Capitation Rate Certification, July 1, 2026 through June 30, 2027, dated April 24, 2026; and

State Fiscal Year 2027 Risk Adjustment Medicaid Managed Care Program, dated April 24, 2026."

13. Attachment J: Special Terms and Conditions- 1. Definitions 7 – Incentive Payments is amended by ***UPDATING*** as follows:

"Incentive payments are payments designed to support program initiatives tied to meaningful quality goals and performance measure outcomes, *and if applicable, are required to comply with all reporting requirements outlined in 42 CFR § 438.3*. The Contractor's receipt of incentive payments is based solely on satisfactory performance and is not conditional on the Contractor's compliance with an Intergovernmental agreement."

14. Attachment J: Special Terms and Conditions – 2. Risk Share/Gain Share Arrangement is amended by ***UPDATING*** as follows:

Risk Share *Provisions*

1. If the actual If the actual cumulative Medical Expenses are between one hundred percent (100%) of the Baseline and *one hundred and two percent (102%)* of the Baseline, the Contractor will bear one hundred (100%) of those expenses.
2. If the actual cumulative Medical Expenses are between *one hundred and two percent (102%)* of the Baseline and *one hundred and four percent (104%)* of the Baseline, the Contractor will bear forty percent (40%) of that expense and EOHHS will bear sixty percent (60%) of that expense.

3. If the actual cumulative Medical Expenses are greater than *one hundred and four percent (104%)* of the Baseline, the Contractor will bear ten percent (10%) of that expense and EOHHS will bear ninety percent (90%) of that expense.

Gain Share *Provisions*

1. If the actual cumulative Medical Expenses are between *ninety-eight percent (98%)* of the Baseline and one hundred percent (100%) of the Baseline, the Contractor will retain one hundred percent (100%) of those gains.
2. If the actual cumulative Medical Expenses are between *ninety-eight percent (98%)* of the Baseline and *ninety-six percent (96%)* of the Baseline, the Contractor will retain forty percent (40%) of those gains and EOHHS' share will be sixty percent (60%).
3. If the actual cumulative Medical Expenses are less than *ninety-six percent (96%)* of the Baseline, the Contractor will retain ten percent (10%) of those gains and EOHHS' share will be ninety percent (90%).

Table 1. Risk and Gain Share Arrangement

Risk Sharing Provisions	**Plan Share of Risk**	**EOHHS Share of Risk**
For Medical Expenses between 100% and *102%* of Baseline	100%	0%
For Medical Expenses between *102%* and *104%* of Baseline	40%	60%
For Medical Expenses greater than *104%* of Baseline	10%	90%
Gain Sharing Provisions	**Plan Share of Gains**	**EOHHS Share of Gains**
For Medical Expenses between *98%* and 100% of Baseline	100%	0%
For Medical Expenses between *98%* and *96%* of Baseline	40%	60%
For Medical Expenses less than *96%* of Baseline	10%	90%

15. Attachment J: Special Terms and Conditions - Additional Special Terms and Conditions is amended by ***UPDATING*** Section 5 Incentive Payments Regulations as follows:

"If the Contractor is eligible for incentive payments, and in accordance with 42 CFR § 438.6(b)(2), payments under incentive arrangements may not exceed one hundred and five (105%) percent of the approved capitation rate since such total payments will not be actuarially sound. Additionally, per 42 CFR § 438.6(b)(2)(i), the incentive arrangement must be for a fixed period and performance and is measured during the rating period under the contract in which the arrangement is applied, *and also follow reporting period requirements of 42 CFR §*

438.3 if applicable. Also, 42 CFR § 438.6(b)(2)(iv) states that participation is not conditional on entering into or complying with an inter-governmental transfer agreement. Please refer to the state's Quality Plan for further information."

IN WITNESS HERETO, the parties have caused this Amendment 21 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
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES:

BY: Richard Charest Digitally signed by Richard Charest Date: 2026.06.24 19:48:18 -04'00'

(Signature)

Richard Charest

(Printed Name)

Secretary

(Title)

6/24/26

(Date)

NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND:

BY: Peter Marino Peter Marino 2026.06.23 09:57:04 -04'00'

(Signature)

Peter Marino

(Printed Name)

President & CEO

(Title)

6/23/26

(Date)

EXHIBIT A

<table>
<tr><th>State Directed Payment Description</th><th>State Directed Payment Requirement</th><th>Effective Date</th></tr>
<tr><td>Ambulance Rates</td><td>Pay no less than the Medicaid FFS Minimum Fee Schedule
No change over SFY 2026
<table><tr><th>Code</th><th>Rate</th></tr><tr><td>A0426: NEMT ALS</td><td>$134.67</td></tr><tr><td>A0427: Emergency ALS</td><td>$213.33</td></tr><tr><td>A0428: NEMT BLS</td><td>$112.22</td></tr><tr><td>A0429: Emergency BLS</td><td>$179.56</td></tr></table></td><td>7/1/2026</td></tr>
<tr><td>Ambulatory Dental Anesthesia Facility Fee</td><td>Pay no less than the Medicaid FFS Minimum Fee Schedule
(% of Medicare)
May use generic Code 41899 in lieu of G-Code
<table><tr><th>Code</th><th>Rate</th></tr><tr><td>41899: Under Other Procedures on the Dentoalveolar Structures</td><td>$1406.50</td></tr><tr><td>G0330: Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia and use of an operating room.</td><td>$1406.50</td></tr></table></td><td>7/1/2026</td></tr>
<tr><td>Certified Community Behavioral Health Clinics</td><td>Pay no less than the Medicaid FFS Minimum Fee Schedule PPS-2 rates.</td><td>10/1/2025</td></tr>
<tr><td>E-Consult</td><td>Pay no less than the Medicaid FFS Minimum Fee Schedule</td><td>10/1/2025</td></tr>
<tr><td>Home Delivered Meals</td><td>Pay no less than the Medicaid FFS Minimum Fee Schedule
<table><tr><th>Code</th><th>Rate</th></tr><tr><td>S5170: Standard</td><td>$13.60</td></tr><tr><td>S5170 U1: Standard</td><td>$13.60</td></tr><tr><td>S5170 U2: Frozen</td><td>$7.37</td></tr><tr><td>S5170 U4:Cultural</td><td>$15.92</td></tr><tr><td>S5170 U5: Therapeutic</td><td>$13.79</td></tr><tr><td>S5170 UF: Shelf Stable</td><td>$7.37</td></tr></table></td><td>7/1/2026</td></tr>
<tr><td>Hospital Inpatient</td><td>Uniform percentage increase - 2.6% Increase over 7/1/2025 rates
-Includes Level IV Detox Services
Contractor must follow payment methodology and state and federal requirements for the Hospital at Home Program. [R.I. Public Law 24419]</td><td>7/1/2026</td></tr>
</table>

EXHIBIT A

State Directed Payment Description	State Directed Payment Requirement	Effective Date
Hospital Labor & Delivery	Pay no less than the FFS Minimum Fee Schedule 2.6% Increase over 7/1/2025 rates Applicable to the following AP-DRGs: 540-1 to 540- 4 541-1 to 541-4 542-1 to 542-4 560-1 to 560-4 *Note that the minimum fee schedule applies irrespective of how the health plan reimburses the hospital for inpatient services.*	7/1/2026
Hospital Outpatient	Uniform percentage increase 2.6% Increase over 7/1/2025 rates	7/1/2026
Nursing Facility	Uniform percentage increase 3.2% Increase over 10/1/2025 rates	10/1/2026
Pediatric E & M Services	Pay no less than the FFS Minimum Fee Schedule	7/1/2026
Primary Care Services	Pay no less than the FFS Minimum Fee Schedule	10/1/2026
Substance Use Disorder Residential	Pay no less than the Medicaid Minimum Fee Schedule	7/1/2026

2.18 COMPLIANCE

2.18.01 General Requirements

In accordance with 42 CFR § 438.608, 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 shall be physically located in and dedicated to the State of Rhode Island, 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 guidelines.
- 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 reporting within thirty (30) calendar days 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.
- Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements. Provision for written policies for all

employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Act, including information about the rights of whistleblowers.

- Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the EOHHS Office of Program Integrity or any potential fraud directly to the EOHHS Fraud Control Unit. 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 CFR § 438.608(a)(4) and 42 CFR § 438.602(b)(2).
- Provision to suspend payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 C.F.R. §455.23.Provision to ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455.400 et. seq.

2.18.02 Compliance with H.R. 6 – The SUPPORT Act

In accordance with Section 1004 of H.R. 6 – The Support Act, the Contractor is required to comply with the following mandates:

- 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).
- Maximum daily morphine equivalent (MME) safety edits; and
- Concurrent utilization alerts for beneficiaries concurrently prescribed opioids and benzodiazepines and/or antipsychotics.

2.18.03 Prohibited Affiliations with Individuals Debarred by Federal Agencies

In accordance with 42 CFR § 438.610, the Contractor may not knowingly have a relationship with the following:

- 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.
- 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:

- A director, officer, or partner of the MCO.
- A subcontractor of the Contractor, as governed by 42 CFR § 438.230.
- A person with beneficial ownership of five (5) percent or more of the MCO's equity.
- A network provider or 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.
- An individual who is excluded from participation in any Federal Health care program under Section 1128 or 1128A of the Act.

- The State must ensure through its contracts that each MCO, PIHP, PAHP, PCCM and any subcontractors: (1) Provides written disclosure of any prohibited affiliation under 42 CFR § 438.610; (2) provides written disclosures of information on ownership and control required under 42 CFR § 455.104 and (3) reports to the state within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

2.18.04 Procedure for Contractor Associating with Prohibited Affiliations

In accordance with 42 CFR § 438.610(d), if the State learns that Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in Federal Healthcare Programs, the State:

- Must notify the Secretary of noncompliance.
- May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
- May not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement.

2.18.05 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:

- Upon the Contractor submitting the proposal in accordance with the State's procurement process.
- Upon the Contractor executing the contract with the State.
- Upon renewal or extension of the contract.
- Within thirty-five (35) days after any change in ownership of the Contractor. The following information will be disclosed by the Contractor, based on 42 CFR §455.104:
    - 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.
    - Date of birth and Social Security Number (in the case of an individual).
    - Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5%) percent or more interest.
    - 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.

- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- The name, address, date of birth, and Social Security Number of any managing employee of the disclosing 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.

2.18.06 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:

- 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.
- Date of birth and Social Security Number (in the case of an individual).
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or in any subcontractor in which the disclosing entity has a five (5%) percent or more interest.
- 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.
- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- 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 § 1001.2.

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 twelve (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.

2.18.07 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 twelve (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 (5) 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.

2.18.08 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:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- 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.

2.18.09 Disclosures Made by Providers to the Contractor

In accordance with 42 CFR §§ 1002.3 and 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:

- Has been convicted of a criminal offense as described in Sections 1128 (a) and 1128(b)(1) through (3) of the Social Security Act
- Has had civil money penalties or assessments imposed under Section 1128(a) of the Social Security Act; or
- Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:
    - A direct or indirect ownership interest of five (5) percent or more in the entity;
    - 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;
    - Is an officer or director of the entity, if the entity is organized as a corporation;
    - Is partner in the entity, if the entity is organized as a partnership;
    - Is an agent of the entity; or
    - 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 § 1001.2:

- 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:

- The capital, the stock, or the profits of the entity, or
- 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.

2.18.10 Compliance with all Rhode Island Regulations

The Contractor agrees to comply with all applicable RI State laws and regulations including but not limited to:

- 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
- 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
- Effective 1/1/2018, R.I Gen. Laws § 27-18.9-8, External Appeals Procedural Requirements

EXHIBIT B

2.18.11 Compliance with all Federal Regulations

The Contractor agrees to comply with all applicable Federal laws and regulations

EXHIBIT C

Placeholder page for Section 2.19 – Program Integrity

2.19 PROGRAM INTEGRITY

2.19.01 General Requirements

The State's EOHHS Office of Program Integrity will oversee all Fraud, Waste, and Abuse activities conducted by the Contractor. The Contractor must comply with all Federal and State requirements regarding fraud, waste, and abuse including but not limited to 42 CFR Part 455, Section 1902 (a)(68) of the Social Security Act, and 42 CFR § 438.608. The Contractor must comply with all written direction by the Office of Program Integrity regarding waste, fraud, and abuse investigations, overpayments, and any other program integrity related activities and reporting. The Contractor must use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to EOHHS' Office of Program Integrity. The Contractor cannot be owned by, knowingly hire, or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in Federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State, in accordance with 42 CFR § 438.610.

2.19.02 Fraud Prevention Program

Pursuant to 42 CFR Part 455 and 42 CFR § 438.608, the Contractor shall implement a Fraud Prevention Program that will detect, prevent, and respond to Fraud, Waste, and Abuse (FWA). This program must meet all Federal and State requirements.

Fraud Prevention Program components shall include:

- A Fraud Prevention Officer who will be dedicated to this Agreement and be responsible for:
    - Providing executive oversight to the Fraud Prevention Program and for developing, implementing, and ensuring compliance.
    - Reporting directly to the Medical Director, Chief Compliance Officer, and Board of Directors.
    - Attending and participating in required EOHHS's quarterly oversight meetings which includes Medicaid Fraud Control Unit (MFCU), as scheduled.

The Contractor shall have written policies and procedures that include clear standards for detecting, investigating, and reporting FWA. Such policies and procedures shall include the following:

- Program Integrity Risk Assessment/Review to efficiently identify high-risk areas (e.g., benefits, claims processing, Providers, and billing)
- An Annual Review to update risk assessments.
- Ad-hoc Reviews following organizational changes in operations or regulations.
- Provider screening and enrollment protocols that include Provider credentialing and verification to confirm provider qualifications, exclusions, and licensing.

- Ongoing monitoring of Providers with quarterly checks against Federal and State exclusion lists (e.g., OIG, SAM)
- Provider Training and Education, including Provider Corrective Action and technical assistance
- Mandatory FWA Training reviewed and approved by the Division of Medicaid's Office of Program Integrity for all employees, contractors, and board Members at personnel onboarding and annually thereafter. This training must contain content that includes key definitions of fraud/waste/abuse, reporting obligations, and penalties for noncompliance.
- Reporting mechanisms including and not limited to confidential hotline, email for anonymous reporting of suspected fraud.
- Non-Retaliation Policy ensuring whistleblower protection.
- Prompt investigation with defined written timelines for reviewing allegations.
- Continuous quality improvement plan with measurable process and outcome objectives.
- Annual Program Evaluation to assess and report program effectiveness.
- Policy updates that adapt to regulatory changes or identified vulnerabilities.

2.19.03 Engagement with EOHHS' Office of Program Integrity

Suspected Fraud and/or Abuse regarding a provider or Member should be addressed to the Division of Medicaid's Office of Program Integrity. The EOHHS Office of Program Integrity should be notified in writing within thirty (30) calendar days of the discovery of any overpayments or underpayments made for services provided to Medicaid beneficiaries by providers. If the Contractor identifies a Subcontractor, Member, or Provider that the Contractor suspects of committing fraud, waste and/or abuse, the Contractor must notify Office of Program Integrity in writing immediately upon discovery and investigate the Subcontractor, Member, or Provider. EOHHS shall direct and conduct investigations related to suspected provider fraud, waste, and abuse cases and reserves the right to pursue and retain recoveries for these investigations.

The Contractor shall be subject to onsite reviews and audits and comply with requests from EOHHS to supply documentation and records. The Contractor and the Office of Program Integrity shall meet monthly, and more frequently as needed, via phone, teleconference, video conference, or in-person to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of fraud, waste, and abuse oversight activities.

2.19.04 Cooperation with Other Agencies

The Contractor must cooperate with all appropriate State and Federal agencies, including the Rhode Island Office of the Attorney General's Medicaid Fraud Control Unit, in investigating fraud, waste and abuse.

2.19.05 Program Integrity Staff

In addition to the Compliance Officer, as outlined in Section 2.18.01 of this Agreement, the Contractor shall employ at least two (2) additional employees who are dedicated staff in a Special Investigations Unit (SIU) and/or auditing unit. Such dedicated staff shall have a regular presence in Rhode Island and the ability to conduct on-site audits.

The Contractor shall, at minimum have one (1) full time investigator physically located within Rhode Island for every fifty thousand (50,000) Members or fraction thereof. This full-time position is in addition to the Compliance Officer and shall be physically located in and dedicated to the State of Rhode Island. EOHHS may, at its sole discretion, consider written requests with detailed justification to substitute another SIU position in place of an investigator position.

The Contractor shall provide EOHHS and the EOHHS Office of Program Integrity the name and contact information of the designated individual within their SIU with whom EOHHS and its Office of Program Integrity shall:

- Communicate directly, and
- Receive access to staff working to identify and resolve specific investigations, audits, or cases of suspected Fraud, Waste, or Abuse.

2.19.06 Provider Site Audits

The Contractor shall complete a minimum of five (5) EOHHS acceptable provider site audits per Contract year that consist of statistically valid random samples of thirty (30) records minimum per provider, or ten (10%) percent of records, sometimes fifty (50) for large populations, to allow for extrapolation.

EOHHS, at its sole discretion, may waive the minimum requirement.

Additional provider on-site audits may be conducted by mutual agreement of EOHHS and the Contractor.

In the event that audit liabilities arising from any discrepancies in payment 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 the repayment of Overpayment within thirty (30) days.
- Offset the amount of Overpayment payments.
-

EOHHS may also refer the matter to the Rhode Island Office of the Attorney General's Medicaid Fraud Control Unit for investigation and/or seek interest on funds pursuant to R.I. Gen. Laws § 40-8.2-22.

If audits discover underpayment to the Contractor, EOHHS will process a corrective payment within thirty (30) days.

EOHHS reserves the right to conduct an onsite audit of the Contractor's Fraud, Waste, Abuse, SIU and Program Integrity activities and files at any time.

2.19.07 Fraud, Waste and Abuse Compliance Plan

The Contractor must have a written Fraud Waste and Abuse Compliance Plan for Rhode Island Medicaid. The Plan, including Fraud, Waste and Abuse Policies and Procedures, must be provided to the EOHHS Office of Program Integrity for written approval within ninety (90) calendar days of execution of this Contract and annually thereafter. EOHHS will provide notice of approval, denial, or modification to the Contractor within sixty (60) calendar days of receipt. Revisions to

an approved compliance plan or fraud and abuse policies and procedures must be submitted to the Office of Program Integrity for written approval at least sixty (60) calendar days prior to the planned implementation of those revisions.

The Contractor shall annually review and submit an updated Fraud, Waste and Abuse Compliance Plan to the Division for approval.

2.19.08 Plan Requirements

The Contractor's Fraud, Waste and Abuse Compliance Plan must:

- Require reporting of fraud, waste, and abuse in compliance with the requirements of this Contract.
- Include a risk assessment of the Contractor's various fraud, waste, and abuse and program integrity processes.
    - A risk assessment must also be submitted when requested by EOHHS and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines), is issued on a provider with concerns of fraud, waste, and abuse. The Contractor must inform EOHHS of such action and provide details of such financial action. The assessment shall also include a listing of the Contractor top three (3) vulnerable areas and shall outline action plans in mitigating such risks.
- Outline unique policy and procedures, including specific instruments to be used.
- Include procedures designed to prevent and detect abuse and fraud in the administration of delivery of services under this Contract.
- Describe of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including but not limited to:
    - A list of automated pre-payment claims edits.
    - A list of automated post-payment claims edits.
    - A list of desk audits on post-processing review of claims.
    - A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.
    - A list of provisions for the investigation and follow-up of any suspected or confirmed fraud, waste, and abuse, even if already reported, and/or compliance plan reports.
- Ensure that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
- Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud, waste, and abuse compliance plan violations.
- Contain specific and detailed internal procedures on how information received from the State regarding providers already under investigation or review is disseminated internally to the appropriate group(s). Specifically, outline the steps that are in place to ensure providers under review or investigation are not contacted or investigated unless approval has been received from the Office of Program Integrity.

- Require any confirmed or suspected provider fraud, waste, and abuse under state or federal law be reported to the Medicaid Fraud Control Unit as well as EOHHS' Office of Program Integrity.
- Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.
- Include provisions about conducting monthly comparison of the Contractor's provider files against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to EOHHS each month. The Contractor must establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure information as provided by EOHHS;
- Include provisions about performing a monthly check for exclusions of their owners, agents and managing employees. The Contractor must establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The Contractor must provide the Division with such database and a monthly report of the exclusion check; and
- Include details regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless EOHHS provides prior approval for a provider type to remain contracted or as otherwise required by EOHHS.
- Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.

The Contractor shall submit to EOHHS or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective.

EOHHS, at its sole discretion, may require that the Contractor modify its compliance plan.

2.19.09 Investigation and Reporting of Fraud, Waste and Abuse

The Contractor shall promptly conduct preliminary investigation of possible acts of Fraud, Waste and Abuse, for all services provided under this Agreement, including subcontracted functions.

The Contractor must report Subcontractor, Member, or Provider fraud and/or abuse that it has reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to EOHHS.

The Contractor must cooperate with EOHHS regarding the investigation. Failure to report and/or cooperate with EOHHS to investigate fraud could result in criminal and/or civil penalties for the Contractor.

EXHIBIT C

The Contractor must report Member or Provider Fraud or Abuse in a format to be specified by EOHHS.

The Contractor must use the most current version of the Program Integrity Fraud and Abuse Standard Operating Procedure for referrals and reporting to EOHHS' Office of Program Integrity

The Contractor is restricted from the following actions once the suspected fraud is substantiated and reported to EOHHS without prior written approval from EOHHS:

- Contact the subject of the investigation about any matters related to suspected and/or confirmed fraud or abuse;
- Enter into or attempt to negotiate any settlement or agreement regarding incidents of suspected or confirmed fraud or abuse; or
- Accept any monetary or other thing of valuable consideration offered by the subject(s) of the investigation in connection with incidents of suspected or confirmed fraud or abuse.

Upon a finding by the Contractor of fraud and/or abuse, the Contractor may disenroll a network provider and request actions to be taken by EOHHS. However, the Contractor cannot indicate to the Provider or Member that they will be disenrolled from Rhode Island Medicaid

2.19.10 Overpayments

The Contractor must implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. The procedures must include a provision for prompt reporting to the State, of all overpayments identified or recovered, specifying the overpayments due to potential fraud, within sixty (60) days.

All prepayment reviews must be pre-approved by the Office of Program Integrity. This includes the Contractor and/or its Subcontractor. The Contractor must submit a written request to the Office of Program Integrity to place providers on prepayment review.

All prepayment reviews must be completed within twelve (12) months of case initiation. The Contractor must re-evaluate the case after the twelve (12) months to determine if the provider's billing practices have changed and a continuation of the prepayment review is necessary to prevent future improper payments or refer the case as a credible allegation of fraud. The Contractor must submit a new written request to the Office of Program Integrity for the new prepayment review. The Contractor cannot use prepayment review to hold claims for an indefinite period.

2.19.11 Recoupment

When recovering funds on behalf of EOHHS, the Contractor will retain any overpayments identified and collected because of the audit if EOHHS approves the investigation. The Contractor will be responsible for collecting the overpayment for any provider audited . If it is determined that the Office of Program Integrity will conduct an investigation, EOHHS will be responsible for collecting the overpayments of Providers audited. The Contractor is not authorized to negotiate recoupment amounts approved and authorized by EOHHS.

The Contractor will be required to report to the Office of Program Integrity annually all Overpayments recovered from providers.

The Contractor is prohibited from taking any action to recoup improperly paid funds already paid or withhold funds potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one (1) or more of the following criteria:

- The improperly paid funds have already been recovered by the State of Rhode Island, either directly by EOHHS or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or
- When the issues, services, or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Rhode Island, are the subject of pending Federal or State litigation or investigation. This prohibition is limited to a specific provider, for specific dates, and for specific issues, services, or claims. The Contractor must confer with the Office of Program Integrity before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible. If the Contractor obtains funds in cases where recovery or withhold is prohibited under this section, the Contractor will return the funds to EOHHS.

2.19.12 Suspension of Payment

The rules that govern payment suspensions based upon pending investigations of credible allegations of fraud apply to Rhode Island MCOs. Each Contractor must cooperate with EOHHS when the Office of Program Integrity imposes payment suspensions or lifts a payment suspension. In accordance with 42 CFR. § 455.23, the Contractor must also suspend payments to the Provider within twenty-four (24) hours of receipt of notification from EOHHS that payments to a provider have been suspended and immediately inform EOHHS of that action. Such suspension shall include any claims that may be ready for payment, unless otherwise stated by EOHHS.

The Contractor must lift a payment suspension within twenty-four (24) hours of receipt of notification from EOHHS of a payment suspension lift and immediately inform the Division of that action. The Contractor shall require its Subcontractors, when applicable, to suspend payments to Providers for all claims the Subcontractor has or may have against any entity that directly or indirectly receives funds under this Contract. The Contractor is responsible for the return of any money paid in error for services provided to a suspended Provider. If the Contractor does not suspend payments to the Provider, or if the Contractor does not correctly report the amount of adjudicated payments on hold, EOHHS may impose contractual or other remedies.

2.19.13 Credible Allegation of Fraud

EOHHS has Statewide authority to prosecute individuals and entities for violations of laws with respect to fraud in the provision or administration of medical assistance under the Medicaid program. In accordance with Federal regulations, the Office of Program Integrity must refer any and all cases of credible allegations of fraud to the MFCU. The Contractor must report cases of fraud after due diligence and investigation reveals a credible allegation of fraud to the Office of Program Integrity immediately. The Office of Program Integrity will determine if a referral is made to MFCU.

All information regarding on-going payment suspensions shall be reported monthly on the EOHHS Monthly Program Integrity Report.

If the Contractor does not suspend payments to the Provider, or the Contractor does not correctly report the amount of the payments held, EOHHS may impose contractual or other remedies in accordance with Article 3, Section 7, "Performance Standards and Damages."

2.19.14 Provider Terminations

EOHHS will not reimburse the Contractor for services rendered by any provider that is excluded or debarred from participation by Medicare, Medicaid, including any other state's Medicaid or CHIP program, except Emergency Services.

The Contractor must terminate and/or exclude from participation the enrollment of any provider that is terminated under Medicaid, Medicare or Medicaid programs of any other state.

The Office of Program Integrity maintains a list of providers whose Medicaid provider agreements have been terminated due to sanction or conviction of fraud.

The Contractor must review the List of Excluded Individual-Entities (LEIE) report and OIG Exclusions Database at least monthly.

EXHIBIT D

State of Rhode Island
Executive Office of Health and Human Services
July 2026 through September 2026 Risk Adjustment
Neighborhood Health Plan
Risk Adjusted Rates

Rate Cell	February 2026 Enrollment	Effective Rate Less CTC and CCBHC PPS PMPM	Adjusted Risk Score	Initial Risk Adjusted Rate	Initial Budget Neutrality Adjustment	Budget Neutral Risk Adjusted Rate	Vaccine Assessment PMPM	Primary Care Assessment PMPM	Adjusted CCBHC PPS PMPM	Adjusted CTC PMPM	Adjusted Premium Tax PMPM	Risk Adjusted Full Rate	Budget Neutrality Adjustment	Final Adjusted Rate	0.5% Withhold	Adjusted Rate Less Withhold	Baseline Medical Expense Less CCBHC PPS and CTC	Adjusted Baseline Medical Expense
RIte Care Children																		
RC - MF<1	3,057	$ 838.33	1.0000	$ 838.33	1.0000	$ 838.33	$ 0.00	$ 0.00	$ 0.00	$ 2.21	$ 17.15	$ 857.69	1.0000	$ 857.69	$ 4.29	$ 853.40	$ 754.49	$ 756.70
RC - MF 1-5	16,588	397.52	1.0138	403.01	1.0010	403.41	-	-	4.34	2.21	8.37	418.33	1.0000	418.33	2.09	416.24	357.35	369.19
RC - MF 6-14	32,470	275.25	1.0138	279.05	0.9993	278.85	-	-	12.93	2.21	6.00	299.99	1.0000	299.99	1.50	298.49	246.49	264.86
RIte Care Children - Composite	**52,115**	**$ 347.20**		**$ 351.31**		**$ 351.32**	**$ 0.00**	**$ 0.00**	**$ 9.44**	**$ 2.21**	**$ 7.41**	**$ 370.37**		**$ 370.37**	**$ 1.85**	**$ 368.52**	**$ 311.57**	**$ 326.92**
RIte Care Adults																		
RC - M 15-44	10,658	$ 326.65	0.9925	$ 324.20	1.0006	$ 324.39	$ 1.61	$ 1.26	$ 11.19	$ 1.15	$ 6.93	$ 346.53	1.0000	$ 346.53	$ 1.73	$ 344.80	$ 296.27	$ 306.57
RC - F 15-44	26,010	496.86	0.9925	493.13	1.0006	493.43	3.78	2.95	16.27	0.47	10.55	527.45	1.0000	527.45	2.64	524.81	450.67	464.30
RC - MF 45+	4,961	777.20	0.9925	771.37	0.9974	769.36	5.32	4.15	13.71	-	16.17	808.71	1.0000	808.71	4.04	804.67	706.12	712.71
RC - EFP	1,140	27.99	1.0000	27.99	1.0000	27.99	-	-	-	-	0.57	28.56	1.0000	28.56	-	28.56	24.49	24.49
RIte Care Adults - Composite	**42,769**	**$ 474.46**		**$ 470.91**		**$ 470.91**	**$ 3.32**	**$ 2.59**	**$ 14.27**	**$ 0.57**	**$ 10.03**	**$ 501.69**		**$ 501.69**	**$ 2.51**	**$ 499.19**	**$ 430.46**	**$ 442.09**
Children with Special Healthcare Needs																		
CSHCN - Adoption Subsidy	2,061	$ 942.27	1.0316	$ 972.05	1.0000	$ 972.05	$ 0.29	$ 0.22	$ 49.61	$ 2.02	$ 20.90	$ 1,045.09	1.0000	$ 1,045.09	$ 5.23	$ 1,039.86	$ 828.27	$ 906.07
CSHCN - Katie Beckett	25	3,049.11	1.0288	3,136.92	1.0029	3,146.02	-	-	21.30	2.10	64.68	3,234.10	1.0000	3,234.10	16.17	3,217.93	2,758.57	2,869.65
CSHCN - Katie Beckett Case Manageme	267	74.82	1.0000	74.82	1.0000	74.82	-	-	-	-	1.53	76.35	1.0000	76.35	-	76.35	67.71	67.71
CSHCN - SSI < 15	2,018	2,826.98	1.0288	2,908.40	1.0004	2,909.56	-	-	48.18	2.21	60.41	3,020.36	1.0000	3,020.36	15.10	3,005.26	2,554.36	2,679.37
CSHCN - SSI >= 15	1,143	1,841.62	1.0288	1,894.66	0.9987	1,892.20	1.87	1.46	70.51	1.08	40.15	2,007.27	0.9999	2,007.07	10.04	1,997.03	1,660.25	1,777.26
CSHCN - Substitute Care	1,690	1,072.82	1.0000	1,072.82	1.0000	1,072.82	1.64	1.28	50.84	1.33	23.02	1,150.93	1.0000	1,150.93	5.75	1,145.18	943.59	995.76
CSHCN - Composite	**7,204**	**$ 1,618.70**		**$ 1,658.75**		**$ 1,658.71**	**$ 0.76**	**$ 0.59**	**$ 50.88**	**$ 1.69**	**$ 34.95**	**$ 1,747.59**		**$ 1,747.56**	**$ 8.72**	**$ 1,738.83**	**$ 1,449.35**	**$ 1,537.82**
Medicaid Expansion																		
ME - F 19-24	4,525	$ 416.82	1.0092	$ 420.65	0.9959	$ 418.93	$ 5.32	$ 4.15	$ 18.65	$ 0.00	$ 9.12	$ 456.17	1.0000	$ 456.17	$ 2.28	$ 453.89	$ 377.61	$ 398.17
ME - F 25-29	2,475	600.45	1.0092	605.97	1.0006	606.33	5.32	4.15	26.44	-	13.11	655.35	1.0000	655.35	3.28	652.07	543.97	575.74
ME - F 30-39	3,013	845.75	1.0092	853.53	1.0017	854.98	5.32	4.15	42.19	-	18.50	925.14	1.0000	925.14	4.63	920.51	766.11	816.66
ME - F 40-49	2,666	1,120.66	1.0092	1,130.97	0.9980	1,128.71	5.32	4.15	49.01	-	24.23	1,211.42	1.0000	1,211.42	6.06	1,205.36	1,015.39	1,071.69
ME - F 50-64	6,468	1,080.70	1.0092	1,090.64	0.9974	1,087.80	5.32	4.15	27.06	-	22.95	1,147.28	1.0000	1,147.28	5.74	1,141.54	981.17	1,014.69
ME - M 19-24	4,551	281.97	1.0092	284.56	0.9964	283.54	5.32	4.15	22.82	-	6.45	322.28	1.0000	322.28	1.61	320.67	254.69	278.92
ME - M 25-29	3,064	432.45	1.0092	436.43	1.0043	438.31	5.32	4.15	32.20	-	9.80	489.78	1.0000	489.78	2.45	487.33	390.65	428.14
ME - M 30-39	5,943	665.15	1.0092	671.27	1.0060	675.30	5.32	4.15	38.81	-	14.77	738.35	1.0000	738.35	3.69	734.66	601.84	649.83
ME - M 40-49	4,262	987.78	1.0092	996.87	1.0021	998.96	5.32	4.15	47.17	-	21.54	1,077.14	1.0000	1,077.14	5.39	1,071.75	895.08	952.38
ME - M 50-64	5,739	1,140.57	1.0092	1,151.06	0.9986	1,149.45	5.32	4.15	30.55	-	24.27	1,213.74	1.0000	1,213.74	6.07	1,207.67	1,035.20	1,073.81
Medicaid Expansion - Composite	**42,706**	**$ 777.76**		**$ 784.91**		**$ 784.86**	**$ 5.32**	**$ 4.15**	**$ 32.60**	**$ 0.00**	**$ 16.88**	**$ 843.81**		**$ 843.81**	**$ 4.22**	**$ 839.59**	**$ 704.94**	**$ 743.97**
Rhody Health Partners																		
RHP - ID	761	$ 1,417.59	1.0091	$ 1,430.49	1.0021	$ 1,433.49	$ 5.32	$ 4.15	$ 6.72	$ 0.00	$ 29.59	$ 1,479.27	1.0000	$ 1,479.27	$ 7.40	$ 1,471.87	$ 1,296.75	$ 1,318.02
RHP - SPMI	956	3,422.01	1.0091	3,453.15	0.9991	3,450.04	5.32	4.15	1,126.82	-	93.60	4,679.93	1.0000	4,679.93	23.40	4,656.53	3,035.61	4,187.29
RHP - Other Disabled 21-44	1,980	1,500.67	1.0091	1,514.33	1.0048	1,521.60	5.32	4.15	17.08	-	31.59	1,579.74	1.0000	1,579.74	7.90	1,571.84	1,371.73	1,407.93
RHP - Other Disabled 45+	3,374	2,394.81	1.0091	2,416.60	0.9985	2,412.98	5.32	4.15	11.39	-	49.67	2,483.51	1.0000	2,483.51	12.42	2,471.09	2,190.16	2,218.16
RHP - Composite	**7,071**	**$ 2,178.14**		**$ 2,197.96**		**$ 2,198.17**	**$ 5.32**	**$ 4.15**	**$ 163.29**	**$ 0.00**	**$ 48.39**	**$ 2,419.32**		**$ 2,419.32**	**$ 12.10**	**$ 2,407.22**	**$ 1,979.14**	**$ 2,160.63**
SOBRA																		
SOBRA	**n/a**	**$ 19,658.54**	**1.0000**	**$ 19,658.54**	**1.0000**	**$ 19,658.54**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 401.19**	**$ 20,059.73**	**1.0000**	**$ 20,059.73**	**$ 0.00**	**$ 20,059.73**	**$ 18,921.35**	**$ 18,921.35**
All Populations - Composite	**151,865**	**$ 649.68**		**$ 654.93**		**$ 654.93**	**$ 2.71**	**$ 2.12**	**$ 26.44**	**$ 1.00**	**$ 14.03**	**$ 701.22**		**$ 701.22**	**$ 3.51**	**$ 697.72**	**$ 587.29**	**$ 619.45**

Notes:
1. February 2026 Enrollment reflects all members fully eligible as of February 2026, including those who were not scored.
2. SOBRA Payments are excluded for purposes of the illustrated February 2026 composites.
3. Values have been rounded.

EXHIBIT E

State of Rhode Island
Executive Office of Health and Human Services
October 2026 through June 2027 Risk Adjustment
Neighborhood Health Plan
Risk Adjusted Rates

Rate Cell	February 2026 Enrollment	Effective Rate Less CTC and CCBHC PPS PMPM	Adjusted Risk Score	Initial Risk Adjusted Rate	Initial Budget Neutrality Adjustment	Budget Neutral Risk Adjusted Rate	Vaccine Assessment PMPM	Adjusted CCBHC PPS PMPM	Adjusted CTC PMPM	Adjusted Premium Tax PMPM	Risk Adjusted Full Rate	Budget Neutrality Adjustment	Final Adjusted Rate	0.5% Withhold	Adjusted Rate Less Withhold	Baseline Medical Expense Less CCBHC PPS and CTC	Adjusted Baseline Medical Expense
RIte Care Children																	
RC - MF<1	3,057	$ 838.34	1.0000	$ 838.34	1.0000	$ 838.34	$ 0.00	$ 0.00	$ 2.21	$ 17.15	$ 857.70	1.0000	$ 857.70	$ 4.29	$ 853.41	$ 754.51	$ 756.72
RC - MF 1-5	16,588	397.53	1.0138	403.02	1.0010	403.42	-	4.44	2.21	8.37	418.44	1.0000	418.44	2.09	416.35	357.36	369.30
RC - MF 6-14	32,470	275.07	1.0138	278.87	0.9993	278.67	-	13.54	2.21	6.01	300.43	1.0000	300.43	1.50	298.93	246.28	265.26
RIte Care Children - Composite	**52,115**	**$ 347.09**		**$ 351.20**		**$ 351.21**	**$ 0.00**	**$ 9.85**	**$ 2.21**	**$ 7.41**	**$ 370.68**		**$ 370.68**	**$ 1.85**	**$ 368.83**	**$ 311.45**	**$ 327.20**
RIte Care Adults																	
RC - M 15-44	10,658	$ 326.01	0.9926	$ 323.60	1.0006	$ 323.79	$ 1.61	$ 12.38	$ 1.15	$ 6.92	$ 345.85	1.0000	$ 345.85	$ 1.73	$ 344.12	$ 295.58	$ 307.10
RC - F 15-44	26,010	495.83	0.9926	492.16	1.0006	492.46	3.78	18.13	0.47	10.51	525.35	1.0000	525.35	2.63	522.72	449.55	465.09
RC - MF 45+	4,961	776.17	0.9926	770.43	0.9973	768.35	5.32	15.31	-	16.10	805.08	1.0001	805.16	4.03	801.13	704.99	713.26
RC - EFP	1,140	27.99	1.0000	27.99	1.0000	27.99	-	-	-	0.57	28.56	1.0000	28.56	-	28.56	24.49	24.49
RIte Care Adults - Composite	**42,769**	**$ 473.56**		**$ 470.06**		**$ 470.05**	**$ 3.32**	**$ 15.89**	**$ 0.57**	**$ 10.00**	**$ 499.82**		**$ 499.83**	**$ 2.50**	**$ 497.34**	**$ 429.48**	**$ 442.76**
Children with Special Healthcare Needs																	
CSHCN - Adoption Subsidy	2,061	$ 941.27	1.0316	$ 971.01	1.0000	$ 971.01	$ 0.29	$ 52.47	$ 2.02	$ 20.93	$ 1,046.72	1.0000	$ 1,046.72	$ 5.23	$ 1,041.49	$ 827.09	$ 907.72
CSHCN - Katie Beckett	25	3,049.15	1.0288	3,136.97	1.0029	3,146.07	-	21.72	2.10	64.69	3,234.58	1.0000	3,234.58	16.17	3,218.41	2,758.59	2,870.09
CSHCN - Katie Beckett Case Managemer	267	74.82	1.0000	74.82	1.0000	74.82	-	-	-	1.53	76.35	1.0000	76.35	-	76.35	67.71	67.71
CSHCN - SSI < 15	2,018	2,826.72	1.0288	2,908.13	1.0004	2,909.29	-	50.13	2.21	60.44	3,022.07	1.0000	3,022.07	15.11	3,006.96	2,553.97	2,680.91
CSHCN - SSI >= 15	1,143	1,840.29	1.0288	1,893.29	0.9987	1,890.83	1.87	73.90	1.08	40.16	2,007.84	0.9999	2,007.64	10.04	1,997.60	1,658.66	1,779.01
CSHCN - Substitute Care	1,690	1,070.85	1.0000	1,070.85	1.0000	1,070.85	1.64	57.58	1.33	23.09	1,154.49	1.0000	1,154.49	5.77	1,148.72	941.08	999.99
CSHCN - Composite	**7,204**	**$ 1,617.67**		**$ 1,657.69**		**$ 1,657.66**	**$ 0.76**	**$ 54.36**	**$ 1.69**	**$ 34.99**	**$ 1,749.46**		**$ 1,749.43**	**$ 8.73**	**$ 1,740.70**	**$ 1,448.07**	**$ 1,539.99**
Medicaid Expansion																	
ME - F 19-24	4,525	$ 415.16	1.0092	$ 418.98	0.9959	$ 417.26	$ 5.32	$ 20.31	$ 0.00	$ 9.04	$ 451.93	1.0000	$ 451.93	$ 2.26	$ 449.67	$ 375.83	$ 398.04
ME - F 25-29	2,475	597.64	1.0092	603.14	1.0007	603.56	5.32	32.16	-	13.08	654.12	1.0000	654.12	3.27	650.85	540.94	578.46
ME - F 30-39	3,013	842.79	1.0092	850.54	1.0017	851.99	5.32	49.20	-	18.50	925.01	1.0000	925.01	4.63	920.38	762.84	820.37
ME - F 40-49	2,666	1,116.93	1.0092	1,127.21	0.9981	1,125.07	5.32	55.07	-	24.19	1,209.65	1.0000	1,209.65	6.05	1,203.60	1,011.34	1,073.77
ME - F 50-64	6,468	1,079.24	1.0092	1,089.17	0.9974	1,086.34	5.32	30.02	-	22.89	1,144.57	1.0000	1,144.57	5.72	1,138.85	979.55	1,016.01
ME - M 19-24	4,551	280.74	1.0092	283.32	0.9964	282.30	5.32	25.00	-	6.38	319.00	1.0000	319.00	1.60	317.40	253.35	279.76
ME - M 25-29	3,064	430.75	1.0092	434.71	1.0044	436.62	5.32	35.68	-	9.75	487.37	1.0000	487.37	2.44	484.93	388.78	429.77
ME - M 30-39	5,943	663.38	1.0092	669.48	1.0060	673.50	5.32	43.10	-	14.73	736.65	1.0000	736.65	3.68	732.97	599.89	652.14
ME - M 40-49	4,262	984.64	1.0092	993.70	1.0021	995.79	5.32	54.29	-	21.54	1,076.94	1.0000	1,076.94	5.38	1,071.56	891.62	956.00
ME - M 50-64	5,739	1,138.73	1.0092	1,149.21	0.9986	1,147.60	5.32	34.41	-	24.23	1,211.56	1.0000	1,211.56	6.06	1,205.50	1,033.15	1,075.60
Medicaid Expansion - Composite	**42,706**	**$ 775.70**		**$ 782.84**		**$ 782.80**	**$ 5.32**	**$ 36.74**	**$ 0.00**	**$ 16.83**	**$ 841.69**		**$ 841.69**	**$ 4.21**	**$ 837.48**	**$ 702.68**	**$ 745.84**
Rhody Health Partners																	
RHP - ID	761	$ 1,417.56	1.0090	$ 1,430.32	1.0021	$ 1,433.32	$ 5.32	$ 7.66	$ 0.00	$ 29.52	$ 1,475.82	1.0000	$ 1,475.82	$ 7.38	$ 1,468.44	$ 1,296.66	$ 1,318.74
RHP - SPMI	956	3,393.46	1.0090	3,424.00	0.9991	3,420.92	5.32	1,201.62	-	94.45	4,722.31	1.0000	4,722.31	23.61	4,698.70	3,000.11	4,226.01
RHP - Other Disabled 21-44	1,980	1,498.80	1.0090	1,512.29	1.0048	1,519.55	5.32	20.55	-	31.54	1,576.96	1.0000	1,576.96	7.88	1,569.08	1,369.73	1,409.24
RHP - Other Disabled 45+	3,374	2,391.91	1.0090	2,413.44	0.9984	2,409.58	5.32	17.28	-	49.64	2,481.82	1.0000	2,481.82	12.41	2,469.41	2,187.01	2,220.44
RHP - Composite	**7,071**	**$ 2,172.37**		**$ 2,191.92**		**$ 2,192.02**	**$ 5.32**	**$ 177.28**	**$ 0.00**	**$ 48.46**	**$ 2,423.09**		**$ 2,423.09**	**$ 12.11**	**$ 2,410.98**	**$ 1,972.27**	**$ 2,167.40**
SOBRA																	
SOBRA	**n/a**	**$ 19,658.55**	**1.0000**	**$ 19,658.55**	**1.0000**	**$ 19,658.55**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 401.19**	**$ 20,059.74**	**1.0000**	**$ 20,059.74**	**$ 0.00**	**$ 20,059.74**	**$ 18,921.36**	**$ 18,921.36**
All Populations - Composite	**151,865**	**$ 648.50**		**$ 653.74**		**$ 653.73**	**$ 2.71**	**$ 29.02**	**$ 1.00**	**$ 14.01**	**$ 700.47**		**$ 700.47**	**$ 3.50**	**$ 696.97**	**$ 585.96**	**$ 620.68**

Notes:
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3. Values have been rounded.