Solicitation Information
March 9, 2018

RFP# 7591562

TITLE: Rhode Island Transportation Brokerage Services

Submission Deadline: April 6, 2018 at 10:00 AM Eastern Time (ET)

PRE-BID/ PROPOSAL CONFERENCE: No

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **March 20, 2018 at 10:00 AM (ET).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

BID SURETY BOND REQUIRED: No

PAYMENT AND PERFORMANCE BOND REQUIRED: Yes

David J. Francis

Interdepartmental Project Manager

Note to Applicants:

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Proposals received without a completed RIVIP Bidder Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER FORM

Table of Contents

SECTION 1. INTRODUCTION 3
Instructions and Notifications to Offerors 3
SECTION 2. BACKGROUND 6
SECTION 3: SCOPE OF WORK AND REQUIREMENTS 18
SECTION 4: PROPOSAL 68
A. Technical Proposal 68
B. Cost Proposal 69
C. ISBE Proposal 69
SECTION 5: EVALUATION AND SELECTION 69
SECTION 6. QUESTIONS 71
SECTION 7. PROPOSAL CONTENTS 71
SECTION 8. PROPOSAL SUBMISSION 73
SECTION 9. CONCLUDING STATEMENTS 73
APPENDIX I. PROPOSER ISBE RESPONSIBILITIES AND MBE, WBE, AND/OR DISABILITY BUSINESS ENTERPRISE PARTICIPATION FORM 74
APPENDIX II. – PERFORMANCE BOND ..... Attached
APPENDIX III. LIST OF BORDER COMMUNITIES ..... Attached
APPENDIX IV. SYSTEMS REQUIREMENTS ..... Attached
APPENDIX V. COVERED SERVICES FOR MEDICAID NEMT ..... Attached
APPENDIX VI. KEY PERSONNEL TABLE ..... Attached
APPENDIX VII. BROKER-TP CONTRACT REQUIREMENTS ..... Attached
APPENDIX VIII. SERVICE COMPLAINTS AND APPEALS ..... Attached
APPENDIX IX. NOTICE OF ADVERSE ACTION POLICY ..... Attached
APPENDIX X. PRICING STRUCTURE AND EXPERIENCE ..... Attached
APPENDIX XI. Transportation Model Contract…… Attached
APPENDIX XII. EOHHS_Appr_837_Encounter_Companion_Guide_version 2.6…. ..Attached
APPENDIX XIII. 834 Companion Guide V1 5_TransBroker……..…….……Attached
APPENDIX XIV Transportation Policy Final April 2016. ……Attached

SECTION 1. INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Executive Office of Health & Human Services (EOHHS) is soliciting proposals from qualified firms to provide brokerage services and management of the daily functions of the Rhode Island Medicaid Non-Emergency Medical Transportation Program (NEMT), the Elderly Transportation Program (ETP), and individuals participating in Temporary Assistance to Needy Families (TANF)/RI Works in accordance with the terms of this Request for Proposals ("RFP") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.purchasing.ri.gov.

The initial contract period will begin January 1, 2019 and will continue through June 30, 2022. Contracts may be renewed for up to three (3) additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not a Request for Quotes. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to cost; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, other than to name those offerors who have submitted proposals.

Instructions and Notifications to Offerors

(a) Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

(b) Alternative approaches and/or methodologies to accomplish the desired or intended results of this RFP are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP may be rejected as being non-responsive.

(c) All costs associated with developing or submitting a proposal in response to this RFP or for providing oral or written clarification of its content, shall be borne by the vendor. The State assumes no responsibility for these costs even if the RFP is cancelled or continued.

(d) Proposals are considered to be irrevocable for a period of not less than 180 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

(e) All pricing submitted will be considered to be firm and fixed unless otherwise indicated in the proposal.

(f) It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

(g) The purchase of goods and/or services under an award made pursuant to this RFP will be contingent on the availability of appropriated funds.

(h) Vendors are advised that all materials submitted to the Division of Purchases for consideration in response to this RFP may be considered to be public records as defined in R. I. Gen. Laws § 38-2-1, *et seq*. and may be released for inspection upon request once an award has been made.

Any information submitted in response to this RFP that a vendor believes are trade secrets or commercial or financial information which is of a privileged or confidential nature should be clearly marked as such. The vendor should provide a brief explanation as to why each portion of information that is marked should be withheld from public disclosure. Vendors are advised that the Division of Purchases may release records marked confidential by a vendor upon a public records request if the State determines the marked information does not fall within the category of trade secrets or commercial or financial information which is of a privileged or confidential nature.

(i) Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

(j) By submission of proposals in response to this RFP vendors agree to comply with R. I. General Laws § 28-5.1-10 which mandates that contractors/subcontractors doing business with the State of Rhode Island exercise the same commitment to equal opportunity as prevails under Federal contracts controlled by Federal Executive Orders 11246, 11625 and 11375.

Vendors are required to ensure that they, and any subcontractors awarded a subcontract under this RFP, undertake or continue programs to ensure that minority group members, women, and persons with disabilities are afforded equal employment opportunities without discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability.

Vendors and subcontractors who do more than $10,000 in government business in one year are prohibited from engaging in employment discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability, and are required to submit an "Affirmative Action Policy Statement."

Vendors with 50 or more employees and $50,000 or more in government contracts must prepare a written "Affirmative Action Plan" prior to issuance of a purchase order.

a. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation.

b. Vendors further agree, where applicable, to complete the "Contract Compliance Report" (http://odeo.ri.gov/documents/odeo-eeo-contract-compliance-report.pdf), as well as the "Certificate of Compliance" (http://odeo.ri.gov/documents/odeo-eeo-certificate-of-compliance.pdf), and submit both documents, along with their Affirmative Action Plan or an Affirmative Action Policy Statement, prior to issuance of a purchase order. For

public works projects vendors and all subcontractors must submit a "Monthly Utilization Report" (http://odeo.ri.gov/documents/monthly-employment-utilization-report-form.xlsx) to the ODEO/State Equal Opportunity Office, which identifies the workforce actually utilized on the project.

For further information, contact Vilma Peguero at the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via e-mail at ODEO.EOO@doa.ri.gov .

11. In accordance with R. I. Gen. Laws § 7-1.2-1401 no foreign corporation has the right to transact business in Rhode Island until it has procured a certificate of authority so to do from the Secretary of State. This is a requirement only of the successful vendor(s). For further information, contact the Secretary of State at (401-222-3040).

12. In accordance with R. I. Gen. Laws §§ 37-14.1-1 and 37-2.2-1 it is the policy of the State to support the fullest possible participation of firms owned and controlled by minorities (MBEs) and women (WBEs) and to support the fullest possible participation of small disadvantaged businesses owned and controlled by persons with disabilities (Disability Business Enterprises a/k/a "DisBE")(collectively, MBEs, WBEs, and DisBEs are referred to herein as ISBEs) in the performance of State procurements and projects. As part of the evaluation process, vendors will be scored and receive points based upon their proposed ISBE utilization rate in accordance with 150-RICR-90-10-1, "Regulations Governing Participation by Small Business Enterprises in State Purchases of Goods and Services and Public Works Projects". As a condition of contract award vendors shall agree to meet or exceed their proposed ISBE utilization rate and that the rate shall apply to the total contract price, inclusive of all modifications and amendments. Vendors shall submit their ISBE participation rate on the enclosed form entitled "MBE, WBE and/or DisBE Plan Form", which shall be submitted in a separate, sealed envelope as part of the proposal. ISBE participation credit will only be granted for ISBEs that are duly certified as MBEs or WBEs by the State of Rhode Island, Department of Administration, Office of Diversity, Equity and Opportunity or firms certified as DisBEs by the Governor's Commission on Disabilities. The current directory of firms certified as MBEs or WBEs may be accessed at http://odeo.ri.gov/offices/mbeco/mbe-wbe.php. Information regarding DisBEs may be accessed at www.gcd.ri.gov.

For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at, (401) 574-8670 or via email Dorinda.Keene@doa.ri.gov

13. HIPAA - Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement

14. Eligible Entity - In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI) , the vendor hereby certifies that it is an "eligible entity," as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

15. Payment and Performance Bond - The successful vendor must furnish a 100% payment and performance bond from a surety licensed to conduct business in the State of Rhode Island upon the tentative award of the contract pursuant to this solicitation.

SECTION 2. BACKGROUND

Definitions:

The following terms which appear in this RFP have the meaning that is defined below for the purposes of this RFP:

Abuse

TP and/or Broker practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the State of Rhode Island, medical harm to the recipient, or a pattern of failing to provide medically necessary services required by a contract resulting from this RFP. (Recipient practices that result in unnecessary cost to the State of Rhode Island also constitute abuse).

Accountable Entity (AE)

An Accountable Entity (AE) is Medicaid's version of an Accountable Care Organization (ACO) where a provider organization is accountable for quality healthcare, outcomes, and the total cost of care of its population.

Action

The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Department; the failure of a Broker to act within the timeframes for authorization decisions set forth in this RFP and a resultant contract.

Additional Stop

All trips have one pickup point and one drop-off point. An additional stop is a pickup point or drop-off point other than the initial pickup and final drop-off points. Additional stops occur when multiple recipients are transported during a single trip or there is a scheduled pharmacy stop.

Administrative Hearing

A formal review by EOHHS that occurs after the Broker and a recipient have failed to find mutual satisfaction concerning decisions rendered such as denials, reductions, suspensions, or terminations of service.

Ambulance

An air or ground vehicle for transporting the sick and injured that is:

A. Equipped and staffed to provide medical care during transit;
B. For the ground vehicle, operated as a ground ambulance under the authority and in compliance with promulgated regulations of the Rhode Island Department of Health;
C. Registered as such by the Rhode Island Division of Motor Vehicles; or
D. For the air vehicle, registered and certified as an air ambulance by an appropriate authority in which the aircraft is located; and,
E. May be used for both Emergency and Non-Emergency Transportation purposes.

Ambulance Service Types

Basic Life Support (BLS) Nonemergency:

Basic life support nonemergency (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician basic (EMT-Basic). The ambulance service and personnel must comply with all relevant RI General Laws and DPH Regulations. Basic life support level services are those performed by personnel certified in Rhode Island as Emergency Medical Technicians (EMT).

Advanced Life Support, Level 1 (ALS):

Advanced life support, level 1 (ALS) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention. An ALS assessment charge is only relevant and reimbursable in an emergency response, which will not be administered by the Broker. An advanced life support (ALS) intervention is a procedure that is in accordance with State and local laws, required to be done by an advanced emergency medical technician (AEMT) or Paramedic. The ambulance service and personnel must comply with all relevant RI General Laws and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements. Advanced Life Support services are those performed by personnel certified in Rhode Island as an Advanced Emergency Medical Technician (AEMT) or Paramedic.

These ambulance services are only available to Medicaid recipients.

Americans with Disabilities Act (ADA) of 1990

A comprehensive, Federal civil rights law that prohibits discrimination against individuals with disabilities in employment, state and local government programs and activities, public accommodations, transportation, and telecommunications.

Appeal

A procedure through which recipients can request a re-determination of Broker actions including, but not limited to, service authorization, denial of service or reduction in the level or mode of service.

Assistance

The physical or communicative help provided by a driver or a person employed by the TP to enable qualified recipients to enter or exit a vehicle or residence.

Authorization

Prior Authorization: Prior authorization is the determination made by the Broker or EOHHS where the Broker verifies eligibility for services and determines the least expensive, medically necessary mode of transportation. This is the primary process for administering the Brokerage service and must be administered to verify client eligibility at the time of the transportation request. and at

monthly intervals when the recipient requests multiple trips that span more than one month. EOHHS also requires the Broker to verify appointments before scheduling a trip.

AVL

Automatic Vehicle Location is a means for automatically determining and transmitting the geographic location of a vehicle. This vehicle location data, from one or more vehicles, may then be collected by a vehicle tracking system to manage an overview of vehicle travel.

Bidder

Any organization or entity that has submitted a proposal to EOHHS in response to this RFP.

Border Community

Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medical Assistance Program, eligible for transportation. A list of those communities is in Appendix III. Out-of-state service restrictions and prior authorization requirements are not imposed on TPs for these communities.

Broker

The entity that contracts with EOHHS to deliver NEMT, ETP and TANF transportation services.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is a division within the United States Department of Health and Human Services. CMS oversees the Medicaid and State Children's Health Insurance Program (SCHIP) programs.

Clean Claim

A bill or invoice for service(s) or goods, a line item of services, or all services and/or goods for a recipient contained on one bill which can be processed without obtaining additional information from the provider of service(s) or a third party.

Complaint

A written or verbal complaint that expresses dissatisfaction with service delivery or any matter other than an "action" as defined herein.

Complaint Tiers

1. Tier one complaints – Issues/incidents involving safety, negligence and injury that require immediate attention. Such issues include injury requiring medical care, accidents resulting in injury, evidence of weapon, assault, incidents that require police assistance, sexual harassment, and other incidents where the recipient in danger.
2. Tier two complaints – Issues/incidents involving service issues such as accidents without injury (with/without police assistance), wheelchair tie-down issues (not resulting in injury), unresolved disagreements, habitual driver no-show/late/rudeness and other disruptions and questionable behaviors
3. Tier three complaints – Issues/incidents involving isolated service or behavior issues such as loud music, isolated provider/recipient late, vehicle cleanliness

Curb-to-Curb Level of Service

Transportation of the recipient from the outside door of his/her residence to the curb in front of the destination, including return trip. The driver may assist the individual to get in and out of the vehicle. The driver does not enter the residence or provider's office.

Current Procedural Terminology (CPT)

Codes published by the American Medical Association used to properly bill for services.

Data Warehouse

A data storage system that consolidates data provided by EOHHS Brokers.

Denial of Authorization

Any rejection, in whole or in part, of an authorization request from a provider for a recipient.

Door-to-Door Level of Service

Transportation of the recipient from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the transport of the recipient from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be ADA (Americans with Disabilities Act) accessible. The driver does not enter the residence or provider's office.

DXC.Technology (DXC)

EOHHS fiscal agent contracted to process and adjudicate claims to support the Rhode Island Medical Assistance Program with which network providers must enroll.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Comprehensive child healthcare services to recipients under twenty-one (21) years of age, including all medically necessary prevention, screening, diagnosis, and treatment services listed in section 1905 (r) of the Social Security Act.

Effective Date of Eligibility

EOHHS's administrative determination of the date an individual becomes eligible for RI Medicaid programs.

Emergency or Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part.

Emergency Ambulance Trip

An ambulance trip made because of an emergency which has as its destination a:

A. Hospital emergency room; or
B. General hospital or psychiatric facility where a nonscheduled admission results; or
C. General hospital or psychiatric facility where an emergency admission results after qualified transportation recipients were seen at a hospital emergency room; or
D. Second facility because an emergency medical service was not available at the original emergency room;

EOHHS

The Rhode Island Executive Office of Health and Human Services

Escort

An individual any age who accompanies the recipient to medical visits for support and assisting in comprehension of medical instruction from medical providers.

Fee-For-Service (FFS)

A method of paying providers for healthcare services in which EOHHS pays providers directly for each service that they render to a Medicaid recipient.

Fraud

Intentional deception or misrepresentation, or reckless disregard or willful blindness by a person or entity with the action could result in an unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable federal or state law.

Good Cause

Legal term denoting adequate or substantial grounds or reason to take a certain action, or to fail to take an action prescribed by law.

Healthcare Common Procedure Coding System (HCPCS)

A system of national healthcare codes that includes the following: Level I is the American Medical Association Physician's Common Procedural Terminology (CPT) codes; Level II covers services and supplies not covered in CPT; and Level III includes local codes used by state Medicare carriers.

Independently Enrolled Provider

A provider with an individual or group practice provider number under which the provider makes claims.

INSIGHT Program

Program offered in RI for individuals who are sight impaired and/or presently registered with the INSIGHT agency.

Institution for Mental Disease

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Integrated Eligibility System (IES)

The sole comprehensive database of the EOHHS' recipient eligibility information.

InterChange (IC)

EOHHS's Medicaid Management Information System operated by DXC.

Managed Care

A system of healthcare that combines delivery and payment and influences utilization of services by employing management techniques designed to promote the delivery of cost-effective healthcare.

Medicaid

The Rhode Island Medical Assistance Program operated by EOHHS under Title XIX of the Federal Social Security Act and related State and Federal rules and regulations.

Medicaid Managed Care Organization (MCO)

An insurer, healthcare center, or other organization that provides, offers, or arranges for coverage of health services needed by plan recipients and uses utilization review and a network of participating providers to administer the provision of healthcare. For purposes of this RFP, "managed care organization" refers to a managed care organization that is under contract with EOHHS to provide contract services to enrolled Recipients.

Medically Necessary /Medical Necessity

The RI Medicaid Program provides payment for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" 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 detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and medically necessary setting and shall not be provided solely for the convenience of the recipient, caretaker, or service provider.

Medically Necessary Mode of Transportation

The least expensive type of transportation that medically meets the physical and medical circumstances of qualified recipient.

Mileage Reimbursement

Mileage Reimbursement refers to compensating the Medicaid recipient, friend, acquaintance of family member on a per-mile basis for transporting an eligible Medicaid recipient to a Medicaid covered service. Additionally, mileage reimbursement is not allowable for the ETP.

Multi-Load

A ride shared by more than one eligible recipient, prior-authorized by the Broker in accordance with EOHHS policies.

NEMT Recipient

A person eligible for and in need of NEMT services.

Non-Emergency Ambulance Trip

A pre-arranged and prior authorized ambulance trip to a non-emergency medical service.

Non-Emergency Medical Transportation (NEMT)

Approved transportation services for Medicaid recipients to receive or to return from receiving medically necessary and non-emergency medical services covered by the Rhode Island Medicaid program.

Normal Business Hours

Normal business hours for the Broker's RI business office will be 8 a.m. to 6 p.m., Monday through Friday except for ten (10) State holidays: New Year's Day, Martin Luther King Day, Memorial Day, July 4th, Victory Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

No Show

Recipient: The failure of a qualified recipient to utilize a scheduled transportation service. Transportation Provider: The failure of a TP to pick up a recipient as scheduled.

Nursing Home

An intermediate care or skilled nursing facility (ICF, SNF, or ICF/MR) or Chronic Disease Hospital.

Out-of-State Trip

A trip originating and/or ending outside Rhode Island that involves the transport of a patient to or from a medical provider that is neither located in Rhode Island nor an approved border community.

Presumptive Eligibility

A status that may be granted by EOHHS to a recipient at the time of processing a Medicaid application, typically indication a recipient is presumed to be Medicaid-eligible.

Primary Care Case Management (PCCM)

Case management-related services, including the locating, coordinating, and monitoring of healthcare services provided by a physician, physician group practice, or an entity employing or having other arrangements with physicians (including nurse practitioners, certified nurse midwives, and physician assistants at the State's option) under a PCCM contract with the State.

Quality Management

A comprehensive program of quality improvement and quality assurance activities that provides sufficient evidence to EOHHS that the Broker and its employees consistently achieve contract terms and performance standards.

RIde Program

The RIde Program, RIPTA'S ADA Comparable Paratransit Service required by the Americans with Disabilities Act (ADA). Paratransit service provided under ADA is available for an individual whose disability either prevents independent use of the fixed route system or prevents travel to or from bus stops.

Ride-Share Program or Vehicle

Vehicle-for-hire program such as Uber and Lyft.

Rhode Island Public Transportation Authority (RIPTA)

RIPTA is a quasi-public, independent authority that is authorized to operate public transit services throughout the state of Rhode Island.

Risk

The possibility of monetary loss or gain by the Broker resulting from service costs exceeding or being less than payments made to it by EOHHS.

Service Animal

Any guide dog, signal dog, therapy animal or other animal trained to provide assistance to an individual with a disability.

Significant Incident

Any incident that results in serious injury, serious adverse treatment, death of a service user, or serious impact on service delivery as defined by EOHHS's policies and procedures or any incident that a prudent person could have expected to result in any of the above.

Stretcher Van

Stretcher van service is a regulated mode of NEMT which may be provided to an individual who cannot be transported in a livery vehicle, taxi, or wheelchair van due to being non-ambulatory and must be transported lying flat. Stretcher van personnel are not required or authorized to provide medical monitoring, medical aid, medical care, or medical treatment of passengers during their transport. Individual passengers may self-administer oxygen. Stretcher van is only available to Medicaid Recipients.

Subcontract

Any written agreement between a Broker and another party to fulfill any requirements of a contract.

Substance Use Disorder (SUD)

A condition in which the use of one or more substances leads to a clinically significant impairment or distress. SUD involves the overuse of, or dependence on, a drug or substance leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others.

TANF (RI WORKS) Program

The TANF (RI WORKS) program provides financial and employment assistance to eligible pregnant women and parents with children. Most RI Works recipients are eligible for Medicaid once they apply. Transportation reimbursement or bus passes are available to support preparation for employment.

Taxi

A "vehicle for hire" operating as a taxi as under the authority and in compliance with promulgated regulations of the RI Public Utilities Commission and registered as such by the Department of Motor Vehicles.

Third-Party

Any individual, entity or program that is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State plan.

Title XIX

The provisions of 42 United States Code Section 1396 et seq., including any addenda thereto. (See Medicaid.)

Transport Time

The expected shortest duration required to transport an individual from a pick-up location to a drop off location without additional stops.

Transportation Provider (TP)

An entity that transports recipients.

TP Agreement

The signed written contract or agreement between EOHHS's transportation Broker and the Provider of Transportation services.

Transportation Vehicle

A vehicle that is:

A. Constructed to carry passengers;
B. Operated under the authority and in compliance with the statutes and regulations of the Department of Transportation and/or a transit district and the Division of Motor Vehicles; and
C. Used for the transportation of recipients.

Trip

The approved and scheduled transportation of a recipient in "permitted" vehicle from an authorized pickup location to an authorized drop off location.

Trip Legs

- A-Leg trip is the trip from the recipient's residence to their trip destination.

- B-Leg trip is the trip from the service provider back to the recipient's residence

Urgent Trip

Unplanned trips provided within 48 hours of scheduling as a result of a recipient's need for medical care due to illnesses or injuries which require prompt attention but are not of such seriousness as to require the services of an emergency room. This includes trips to SUD, medication assisted treatment facilities.

Utilization Management

The prospective, retrospective, or concurrent assessment of the necessity and appropriateness of the allocation of healthcare resources and services given, or proposed to be given, to an individual within the State of Rhode Island receiving benefits or entitled to receive benefits under applicable programs.

Waiting Time

The time that a vehicle is waiting at a medical provider's facility, to which the TP transported the recipient, in order to transport the recipient to another destination, during the same trip or the time that a vehicle is waiting at the pick-up location, whether a medical provider's facility or the recipient's residence, in order to transport to or from a medical appointment.

Wheelchair Van

A. A motor vehicle (sometimes referred to as a "wheelchair accessible livery van") that is:

1) Specifically equipped to carry persons who are mobility challenged or otherwise rely on wheelchairs; and

2). Used exclusively for the transportation of non-ambulatory patients in wheelchairs that can be appropriately secured for transport according to vehicle and wheelchair design standards; and

3). Registered as such by the Division of Motor Vehicles.

B. A motor vehicle operated as an invalid coach under the authority and in compliance with promulgated regulations of the RI Division of Emergency Medical Services or alternatively operated as a wheelchair accessible livery vehicle by the Department of Transportation, and registered as such by the Division of Motor Vehicles.

2.1 OVERVIEW OF THE RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Under state law, EOHHS serves as "the principal agency of the executive branch of state government" (R.I.G.L. § 42-7.2-2) responsible for managing the departments of: Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Last year, these agencies provided direct services to nearly 306,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services to the state's communities. Health and human service benefits represent $3.5 billion in spending per year, or over 38 percent of the entire state budget.

EOHHS is the single state agency for Medicaid. This procurement is to secure the services of a qualified Brokerage firm (Broker) to provide transportation to eligible and enrolled NEMT recipients, eligible ETP residents and TANF recipients. Currently, these services are provided by a single broker. EOHHS welcomes potentially qualified new bidders with the capabilities to provide high-quality, reliable, and cost-effective services to all eligible populations.

EOHHS will conduct a readiness review with the approved Broker to ensure that the Broker is prepared to meet the requirements of the transportation services to all eligible populations as presented in its submission.

This section provides potential Bidders with background information on the three programs (NEMT, ETP and TANF transportation) and the goals of the procurement

2.2 OVERVIEW OF THE RHODE ISLAND NEMT, ETP AND TANF PROGRAMS

Under Federal regulations, states are required to provide transportation to Non-Emergency Medicaid-funded services for Medicaid eligible individuals who have no other means of transportation. Ensuring transportation to necessary non-emergency medical appointment services is a critical aspect of delivering medical care to the Medicaid population.

Transportation is often cited as a barrier to accessing care and necessary services. Offering supportive services, like transportation, that assist residents in staying in community-based settings is consistent with the State's long-term goals around shifting expenditures from high-cost institutional settings to community based settings.

Rhode Island is also able to provide transportation to eligible elderly residents under the State's ETP. This program provides transportation to and from non-emergency medical appointments, adult day care, meal sites, dialysis/cancer treatment centers and the INSIGHT Program. This Program is both federally and state-funded and subject to eligibility criteria, state funding and restrictions as noted in Rhode Island Rules and Regulations Section 1360. These regulations are available at:

http://sos.ri.gov/documents/archives/regdocs/released/pdf/EOHHS/8334.pdf

2.2.1 Evolution of NEMT, ETP and TANF transportation

In May of 2014, the State of Rhode Island implemented a broker model for the administration of the NEMT, ETP and TANF transportation. Prior to this model the State administered the program.

The brokered delivery system has provided significant advances by allowing the state to accurately track transportation services and costs associated with the program. Although there have been significant improvements under the current brokered system, the State seeks to improve upon its program requirements through this RFP to ensure that all eligible populations have access to safe and professionally managed transportation services that is least costly to the State.

EOHHS is looking to continue the broker model to implement an even more responsive and accountable transportation service that offers safe, high-quality, and efficient transportation to all eligible recipients of the three programs.

2.2.2 Covered Population

The Broker will be required to screen all recipients who request transportation under this program to assess this eligibility. This service is offered as a last resort when recipients are not able to provide their own transportation or get transportation from family members, friends, other State programs or other parties.

Successful bidders shall be required to cover the following groups:

Medicaid Eligible and Enrolled Recipients

NEMT program is a service offered to all Medicaid recipients who need medical services. It provides non-emergency transportation services for recipients to medical appointments and other Medicaid covered services including transportation to the Rhode Island VA medical centers. This service is offered as a last resort when the Medicaid recipients is not able to provide his/her own transportation or receive transportation from a family member, friend, or other party.

Eligible Medicaid recipients include adults and children who live in a community setting and are receiving medical assistance benefits through RI Medicaid's managed care and fee-for-service arrangements.

Temporary Assistance for Needy Families (TANF)

All recipients of the TANF Program (also known as RI Works) are eligible to receive a monthly bus pass, including adults and children. This bus pass is provided to assist these recipients to pursue employment opportunities.

Non-Medicaid Elderly Population

ETP, pursuant to EOHHS Rules and Regulations Section 1360.06 –1360.08, provides transportation for individuals aged 60 years and older who are not getting transportation from the RIPTA RIde Program, the RIPTA Free Bus Program, or from the Americans with Disabilities Act (ADA) Program. The Broker will be required to screen all elderly who request services under this program to assess their eligibility for the RIPTA RIde Program or the ADA Program.

2.2.3 Current Usage

A detailed profile of program utilization can be found in Appendix X.

2.3 STRATEGIC GOALS FOR THIS RFP

Access to quality transportation services is integral to meeting the diverse health needs of the populations served in EOHHS programs. Reliable, safe, and efficient transportation supports healthier outcomes for program recipients. EOHHS is looking to further the brokered delivery system currently operating in Rhode Island and expand and improve in the following areas:

- Increase available capacity by improving efficiencies within transportation delivery system;
- Improve service management and monitoring to prevent fraud, waste, and abuse (FWA);
- Ensure cost-effective transportation, streamlining, and standardizing the program and Broker management requirements and contract and more fully utilizing vehicles and resources within a coordinated system;
- Enhance consumer safety by developing comprehensive standards;
- Refine service requirements and performance standards;
- Improve overall consumer satisfaction with services provided;
- Develop and enhance the existing TP network
- Create alternative options for transportation, including services provided by volunteer networks, community based organizations, community health teams, on-demand transportation etc.,
- Closer collaboration with Medicaid Managed Care Organizations (MCOs) and Accountable Entities (AEs), and;
- Support residents staying in community-based settings to further the State's health system transformation goals.

Where technology advancements can be applied, EOHHS encourages the Broker to utilize such technology. Broker should describe, in detail, how implementation of technology will improve and expand on the items listed above.

These strategic goals form the basis of the approach for the Broker to provide transportation services to recipients. More specific goals for each sub-population are outlined below.

2.3.1 Medicaid Population

EOHHS seeks to continue to serve Medicaid eligible recipients with transportation to Medicaid covered services. In a continued effort to reduce overall costs and as EOHHS transitions to value-based payment arrangements, EOHHS is interested in strategies to integrate paying for outcomes and/or providing incentives for better quality and more efficient delivery of transportation services.

There is particular interest around better understanding the main drivers of usage and cost and proposing innovative ideas to improve efficiency and cost-effectiveness.

2.3.2 TANF Population

For this small, specific population, EOHHS is interested in a program design that efficiently, timely, and cost-effectively administers public transit bus passes to this group.

2.3.3 ETP Population

Funding for this population should reflect that the recipient is responsible for paying a $2.00 co-payment for each leg. (A leg is defined as one-way portion of the trip, a round trip to/from an approved destination would include two {2} legs.) This is the responsibility of the Broker to collect, with the expectation that the Broker will retain the co-pay collected. These copayment collections are to be considered in the pricing schematic for ETP. EOHHS is interested in innovative approaches to maintain collection rates while reducing the burden on individual drivers and ETP recipients. EOHHS is also interested in approaches that will ensure the provision of high-quality, customer-centric services to this population for the full State Fiscal Year (SFY).

2.4 SPECIFIC REQUIREMENTS

EOHHS seeks to award a contract for a three-and-a-half-year period, with three one-year renewal options.

There are three (3) populations covered under the Rhode Island NEMT Program:

1. Medicaid recipients
2. TANF/RI Works recipients
3. ETP recipients

The successful bidder will be responsible for providing transportation for all three populations.

2.5 AUTHORITY

Federal requirements regarding non-emergency medical transportation services are described in 42 CFR §440.170(a)(4).

SECTION 3: SCOPE OF WORK AND REQUIREMENTS

EOHHS seeks to continue using a centrally-managed transportation system by using the most cost-effective medically-necessary transportation mode available. The Broker will be responsible for arranging and securing transportation when eligible recipients do not have access to other modes of transportation. These services shall be delivered in a responsive and timely manner and provide opportunities and incentives to improve overall cost-effectiveness and program efficiency.

EOHHS will oversee the delivery system of the Broker to ensure program goals and standards are being met for all programs. EOHHS will establish formal agreements to establish clear lines of responsibility, commitment, and accountability.

The Broker must coordinate with all relevant agencies in the delivery of transportation services to provide the most customer-centric service possible.

The provisions and conditions of this RFP are subject to amendments based on changes to applicable Federal and State laws and regulations which govern this document. The Broker shall work with EOHHS to implement the changes.

Offeror Eligibility

Private provider organizations (defined as non-state entities that are either nonprofit or proprietary corporations or partnerships), RI State agencies, and municipalities are eligible to submit proposals in response to this RFP. Individuals who are not a duly formed business entity are ineligible to participate in this procurement.

Minimum Qualifications of Offerors

To qualify for a contract award, a Bidder must have the following minimum qualifications:

1) EOHHS will only evaluate proposals from organizations that have a minimum of ten (10) years of demonstrated experience in the leadership and operational success of administrating and implementing transportation services to Medicaid Recipients and/or other populations.
2) Have an industry-acceptable means to authorize payments, communicate and transmit HIPAA compliant authorized clean claims data to EOHHS's certified claims payment system utilizing the ASC X12N 837 Healthcare Claim Professional or the capability to accept and process the ASC X12N 997 Functional Acknowledgement and the ASC X12N 835 Healthcare Claim Payment/Advice. See Appendix IV (systems requirements).
3) Maintain current and future HIPAA compliance formats;
4) Process and pay 95% of clean claims to TPs within 30 days of submission; and,
5) Ensure provision of a robust delivery network.
   Specific Activities / Tasks

EOHHS seeks responses from qualified organizations to provide NEMT, ETP and TANF transportation, in a manner consistent with applicable state and federal laws and in a fiscally sound manner. The key outcome for the Broker is to find the best quality, most cost-effective transportation available, while ensuring that recipients arrive at the designated destination on time, safely and are treated with respect and dignity.

The Broker will develop policies and procedures for authorizing, scheduling, managing, and making payment for all transportation services. The actual transportation services under this RFP will be provided through subcontracts between the Broker and TPs. The Broker will be responsible for payment of transportation services furnished through subcontracts with TPs.

The Broker will need to ensure the following programmatic elements are achieved.

a) Provide quality non-emergency transportation services to all eligible recipients;
b) Fulfill all verified trip requests and ensure that all trips are completed safely and on-time;
c) Ensure TPs are willing and able to provide services to all recipients, regardless of geographic location, health status, sex, age, race, ethnicity, color, sexual orientation, gender identity, national origin, religious affiliation, or need for transportation services; and promote a comprehensive transportation network that that does not permit adverse selection;

d) Address TPs' challenges as a result of working in diverse home and geographical environments;
e) Collaborate and communicate with the State's Medicaid Managed Care Health Plans (MCOs) and Accountable Entities (AE's) to provide safe, timely, coordinated and medically suitable transportation to medical care, including behavioral healthcare;
f) Focus on program integrity, FWA prevention and detection;
g) Develop policies and procedures for authorizing, scheduling, managing, and making payments for all non-emergency transportation;
h) Subcontract with TPs and ensure access to high-quality transportation services in all regions of the State;
i) Pay clean claims within 30 days;
j) Minimize administrative burden on TPs.

Covered Services and Modes of Transportation

Medicaid Population

Recipients eligible for Medicaid are eligible to receive transportation from any of the following modes, as medically determined by the needs of the recipient:

- Public Transit (bus)
- Taxi
- Ride-Share Program (Uber/Lyft)
- Public Motor Vehicle
- Multi-Passenger Van
- Wheelchair Van
- Ambulance (stretcher van, ALS/BLS)
- Mileage Reimbursement

Public transit shall be the mode of transportation when both the recipient and the Medicaid service provider are located within one-half (1/2) mile of an established bus stop. The Broker must request documentation of medical necessity from the recipient's medical/behavioral health provider for all transportation modes except for public transit (bus) and mileage reimbursement.

Mileage Reimbursement is provided for prior-authorized non-emergency medical transportation to a Medicaid recipient's covered service appointment. The recipient, friend, or family member responsible for transporting the Medicaid recipient qualifies for mileage reimbursement if they are unable to provide transport without financial assistance.

If medically (physical or mental health) justified and communicated during the reservation, an additional person can be permitted to accompany a recipient. An escort must accompany all children under the age of 18 years. Adult recipients who need transportation to their own Medicaid covered service may have a child accompany them.
A list of covered services for NEMT is provided in Appendix V. This list is subject to change.

ETP

ETP, pursuant to EOHHS Rules and Regulations Section 1360.06 –1360.08, provides transportation for individuals aged 60 years and older who are not getting transportation from the RIPTA RIde Program, the RIPTA Free Bus Program, or from the Americans with Disabilities Act (ADA) Program. Service provision is contingent upon available state funding.

ETP includes the following modes of transportation:

- Public Transit (bus)
- Taxi
- Ride-Share Program (Uber/Lyft)
- Public Motor Vehicle
- Multi-Passenger Van
- Wheelchair Van

ETP does not provide ambulance transportation, including stretcher van, ALS, and BLS.

Mileage reimbursement is not available for the ETP program.

A full description of ETP is at:
http://sos.ri.gov/documents/archives/regdocs/released/pdf/EOHHS/8334.pdf

TANF

This population is eligible for public mass transit (bus) passes only. It is critical that the bus passes are provided timely to this population so they can continue their activities toward employment.

LEVELS OF SERVICE

The broker will be responsible for providing two levels of transportation for both NEMT and ETP recipients:

Curb-to-Curb Service: (see definitions section)

Door to Door Service: (see definitions section)

3.1 COORDINATION OF SERVICE DELIVERY SYSTEMS

The Broker shall coordinate or consolidate as many service delivery functions as possible, such as call centers, trip assignment functions and eligibility verification. The Broker shall ensure call center staff are able to assign trips for all populations, verify recipients' eligibility, and determine least costly mode of transportation based on medical necessity.

Transportation service region includes all cities and towns in the State of Rhode Island. NEMT also includes transport to authorized border communities and approved

out-of-state trips. ETP provides transportation to border communities if the destination is the closest to the recipient's home. Prior approval in accordance with existing EOHHS policies is needed for out of state medical trips. Prior approval is not needed for allowable transportation to authorized border communities. A list of authorized border communities is included in Appendix III.

3.2 DATA REPORTING

Provide dynamic dashboard data reporting to EOHHS in real time that provides key operational and performance metrics, including trip fulfillment and complaint information. Specific data reporting requirements are detailed in section 4.5.10 of this RFP.

3.3 MANAGEMENT OVERSIGHT CONTROLS

Broker to provide effective management, oversight, and quality control of services by reviewing and modifying service rules, regulations, and policies to establish an efficient and cost-effective service delivery system.

Specific oversight includes:

- Monitor recipient access and complaints to ensure that transportation is timely and that TP personnel are licensed, qualified, competent, courteous, and able to transport recipients in a safe manner.

- Regular auditing and oversight to ensure the quality and timeliness of the transportation services provided and that recipients can access required medical care and services when needed.

- Ensuring that the TPs have not been debarred from participation in a federal program, have attested that there is not a conflict of interest and have provided the required disclosures. (42 CFR 440.170(a)(4)(ii) & 42 CFR 1001.1001)

3.4 COST CONTROL

Broker must forecast, monitor, and control the overall costs of transportation services by assigning trips to the lowest cost, medically necessary mode available. Broker must also identify mechanisms and implement systems to resolve access; quality, FWA, management, and payment issues.

The Broker must implement a system, consistent with EOHHS regulations, to monitor utilization of ETP services that provides the ability for the State to limit or temporarily discontinue services if funding allocated for this program is reduced or exhausted.

Bidders should describe, in detail, their approach to providing transportation services under this contract. Bidders, in describing their approach, should, at a minimum, restate each of the items below and provide their response (approach) to that item immediately thereafter.

3.5 BROKER GENERAL COMPLIANCE REQUIREMENTS

The Broker is responsible for developing, managing, and continually improving a transportation delivery system that provides recipients with access to high-quality transportation services utilizing the most cost-effective transportation mode based on medical necessity.

The Broker shall have a Consumer Advisory Committee. EOHHS shall approve the composition of this committee. At a minimum, this Consumer Advisory Committee shall meet on a quarterly basis.

The Broker shall provide transportation services to all eligible recipients in accordance with CMS guidance which can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/nemt.html. CMS must review and approve the Broker's contract no later than 90 days prior to the effective date of the contract.

The Broker shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

The Broker shall be fully compliant with the following laws and regulations relating to confidential healthcare and substance use treatment:

- Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Public Law 104-191, titled "Administrative Simplification" and the rules and regulations promulgated there under and shall implement these rules and regulations so as to achieve consistency in data collection, validation, storage, retrieval, and consolidation with all EOHHS programs.
- HIPAA data security requirements, the Federal Information Security Management Act of 2002 and H*ealth Information Technology for Economic and Clinical Health Act (HITECH).*
- 38-2-3(d) of the Rhode Island General Laws, entitled "access to public records" and described in "access to Department of Health records.")
- Federal Regulation 42 CFR, Part 2
- Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26
- Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq,
- Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, together commonly known as the Affordable Care Act or ACA, as amended, as instituted in the State of Rhode Island.

- Section 1557 of the Patient Protection and the Affordable Care Act

The Broker shall take security measures to protect against the improper use, loss, access of, and disclosure of any confidential information it may receive or have access to under this Agreement, or which becomes available to the Broker in carrying out this Agreement. The Broker agrees to comply with the requirements of EOHHS for safeguarding of aforementioned information. Confidential information includes, but is not limited to: names, dates of birth, home and/or business addresses, social security numbers, protected health information, financial and/or salary information, employment information, physical and behavioral health services provided, social and economic conditions or circumstances.

In the event of a breach of confidential information the Broker will notify EOHHS within 24 hours with an initial report of the incident.

The Broker will participate and provide support in all state and federal audits, surveys, and agency monitoring and participant appeals. Support shall include, but is not be limited to, producing documentation, gathering data, coordinating formal responses, preparing transmittal letters, and assisting EOHHS in responding to questions from any entity concerning contracted transportation services. The key elements reviewed may vary from year to year.

The Broker will have a comprehensive, written compliance plan which includes a FWA monitoring program that describes specific internal controls, policies and procedures and data analytics designed to prevent and detect FWA in the administration and delivery of transportation services under this contract. The compliance plan is due within 90 days of execution of the agreement and annually thereafter. All suspected FWA incidents shall be reported within the time frames established by EOHHS. In addition, FWA policies and procedures are to be included in the Broker's TP manual. This TP manual must be developed and approved by EOHHS within 60 days prior to go live and will be made available on the Broker's website

The Broker shall maintain detailed records documenting the costs and expenses incurred pursuant to this contract, for the purpose of monitoring and evaluation by EOHHS and other State and Federal personnel. The Broker shall have the capacity to deliver and reproduce documents as requested within five (5) business days of a submitted request.

In accordance with 42 CFR 438.610, the Broker must demonstrate that it has a process to ensure that it prohibits affiliations with individuals who are debarred from Federal or State program participation.

Within 90 days of an awarded contract and then annually thereafter, the Broker must submit completed forms documenting full and complete disclosure of the Broker's ownership and controlling interest, formatted in conformance with the requirements established by EOHHS.

The Broker is required to report to EOHHS within ten (10) calendar days any TP removed from the network for quality or program integrity issues.

3.6 Prohibitions

3.6.1 The Broker is subject to the requirements related to prohibitions on referrals and conflicts of interest as described at 42 CFR 440.170 (a) (4) (ii).

3.6.2 The Broker (including Key Personnel) is prohibited from directly providing transportation services.

3.6.3 The Broker is prohibited from providing transportation services, making a referral to, or subcontracting with, a TP, if the Broker has a financial relationship with the TP or has an immediate family beneficiary who has a direct or indirect financial relationship with the TP. Please see 42 CFR §440.170(a)(4) (ii). As defined in 42 CFR §411.354(a), financial relationship means a direct or indirect ownership or investment interest in any entity that furnishes designated health services or a direct or indirect compensation arrangement with any entity that furnishes designated health services. No employee of the Broker who can influence or award trip assignments may engage in activities in a related business that may be construed to have a conflict of interest.

3.6.4 The Broker shall be liable for the full cost of services resulting from a prohibited referral or subcontract.

3.6.5 The Broker is prohibited from withholding necessary transportation from a recipient for the purposes of financial gain, or any other purpose.

3.6.6 The Broker is prohibited from authorizing transportation that is not the most cost effective, mode of transportation based on medical necessity for a recipient for the purposes of financial gain, or for any other purposes.

3.6.7 The Broker is prohibited from paying more for fixed route public transportation than the rate charged to the general public.

3.6.8 Brokers that are governmental entities are prohibited from paying more for public paratransit services than the rate charged to other state human service agencies for comparable services.

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

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation;
2. An individual or entity that is excluded from participation in any Federal healthcare program under section 1128 or 1128A of the Act.

A "relationship" referred to herein is described as:

- A director, officer, or partner of the broker;
- A subcontractor of broker;
- A person with beneficial ownership of 5 percent or more of the broker's equity;
- A network provider or person with an employment, consulting, or other arrangement with the broker for the provision of items and services that are significant and material to the broker's obligations under its contract with the State.

3.7 FRAUD, WASTE, AND ABUSE REPORTING

The Broker is required to report any suspected cases of TP, recipient, or healthcare provider FWA within 48 hours following the conclusion of its initial investigation, to EOHHS Medicaid Contract Officer and/or designee, as well as the EOHHS Office of Program Integrity (OPI). EOHHS OPI

will review and process the referral and if warranted, submit to the Rhode Island Attorney General Medicaid Fraud Control Unit (MFCU) and/or request additional evidence from the Broker.

The Broker will utilize a State provided template to make a referral in a secure, timely, and thoughtful manner as well as to alert EOHHS of a notification or "tip". The Broker will participate in Medicaid Fraud and Control (MFCU) quarterly meetings.

In addition to reporting any suspected cases of FWA within 48 hours days following the close of an initial investigation, the Broker shall submit monthly reports to EOHHS documenting the Broker's open and closed cases. The monthly reports shall be formatted in conformance with requirements established by EOHHS and shall document all open and closed cases of suspected FWA.

3.8 STAFFING

The Broker must maintain sufficient levels of supervisory and support staff with sufficient training and work experience to perform all contract requirements on an ongoing basis, including a general manager and key staff. EOHHS shall have the right to require reassignment or removal of any staff found unacceptable to EOHHS. The Broker will be required to provide planned physical location of staff, requirements for start-up, implementation, and ongoing operations. A proposed staffing plan must be submitted to EOHHS showing personnel categories and staffing equivalents for major categories of staff assigned to each activity. The staffing plan should show key personnel assigned for this project. The Broker may propose multiple roles for a key person, but overlapping responsibilities and transition between roles must be explained. Responses must identify the persons proposed for the key positions by name; including resumes and a short narrative description summarizing relevant experience of all proposed key personnel. Resumes should include relevant project experience, description of the person's role on the project, dates of participation, and three references with names, addresses, telephone numbers and e-mail addresses.

The Bidder shall propose a staffing model in its response. The Bidder must submit an organization chart for all key personnel and provide an updated organization chart with contact information for all key personnel no longer than 10 days after hire.

3.8.1 Key Personnel

Appendix VI details all key personnel that need to be in the bid. The Broker must complete this table in its bid.

3.8.1.1 General Manager

The Broker shall appoint and maintain, subject to written EOHHS approval, a full time General Manager for this contract. The General Manager must have sufficient authority for resource control to manage the allocation of resources to meet all RFP requirements without service interruption. The General Manager must be located fulltime on site in Rhode Island for the duration of this contract.

3.8.1.2 Key Staff

The Broker shall hire, or assign, qualified staff to certain key positions (see Appendix VI), for purposes of managing the transportation program for the duration of the contract. Each position is not required to be filled by one individual, but someone in the organization must be designated

as General Manager for this project. All positions shall be described in detail in this section and are to be reflected within the larger organizational chart to be provided by the Broker. If a staffing model or formula will be used to determine Full-Time Employees (FTEs), the Broker will share this with EOHHS

The Broker must demonstrate an ability to retain qualified/trained staff ensuring that consistent and accurate program information is provided to recipients, TPs, and facilities.

3.9 BUSINESS OFFICE AND CALL CENTER LOCATION

The Broker shall have a duly licensed, non-residential administrative office ("central business office") that is reasonably accessible to the EOHHS Office (located in the Pastore Complex in Cranston, RI). The location and accessibility of the central business office will be considered as part of the technical evaluation. This office must be open to conduct the general administration functions of the Broker during normal business hours Monday through Friday, except on legal state holidays. The call center must be co-located with the Administrative Office. Specific call center requirements can be found in Section 4.5.2.

All documentation must reflect the Broker's street address, local and toll-free telephone number. The General Manager of the contract must be located at the central business office.

The Broker must have the capacity to send and receive facsimiles at the central business office at all times. The Broker's central office must be equipped with an adequate high-speed Internet connection. The Broker must provide a separate administrative telephone number that will enable EOHHS staff to reach the General Manager directly, without going through other office staff. The Broker must also have the capacity to reproduce documents upon request at no cost to EOHHS.

3.10 OPERATIONAL REQUIREMENTS

3.10.1 Broker Ability to Fulfill Recipient Requests

The Broker must demonstrate the ability to fulfill transportation requests for all eligible recipients, including being willing and able to fulfill requests for hard to serve recipients.

3.10.1.1 Process Trip Requests

The Broker will ensure timely response for all recipient telephone calls, and ensure that each recipient's eligibility is verified and scheduled with the correct level of service based on medical necessity. The Broker's Operations Manual shall include written policies and procedures that detail the transportation services scheduling operations to include:

A. Using EOHHS eligibility file to verify the address of the recipient;

B. Alternative or temporary addresses shall be received. Requests from temporary alternative addresses may be accepted on an exception basis. Acceptable temporary alternative addresses include, but are not limited to:

    a. Addresses of a family member or friend who is the temporary care-taker for the member who requires recovery assistance;

b. Addresses of shelters;

c. A nursing home address instead of the actual residence address; and

d. Other circumstances approved by EOHHS.

C. Verifying whether the purpose of the trip is for a Medicaid, TANF or ETP covered service;

a. Determining the correct mode of transportation and level of service based on medical necessity;

b. Authorizing transportation services on a per-trip or recurring basis; and

c. Scheduling, grouping, and assigning trips.

A process will be developed in conjunction with EOHHS whereby when the Broker learns of a change in address of a recipient's residence, they notify EOHHS so the record on file can be updated with the new address.

The Broker shall sequentially accept recipients in the order in which they request transportation services without restriction. Recipients requesting transportation services shall not be discriminated against on the basis of health status, sex, age, race, ethnicity, color, sexual orientation, gender identity, national origin, religious affiliation or need for transportation services. No policy or practice that has the effect of discriminating on the of health status, sex, age, race, ethnicity, color, sexual orientation, gender identity, national origin, religious affiliation or need for transportation services shall be used. There may be extenuating circumstances outside the control of the broker that may require prioritizing transportation on the basis of health status.

3.10.1.2 Verify Recipient Eligibility

Medicaid and TANF recipient eligibility verification status shall be conducted for each trip by using at the minimum an EOHHS eligibility file. The Broker must verify recipient eligibility regardless of who initiates the request. The Broker shall be solely responsible for payment for any trips scheduled for ineligible individuals.

3.10.1.3 Process Requests for Disenrollment

When a recipient has demonstrated a pattern of continued noncompliance with transportation guidelines (e.g. no-shows or disruptive behavior), the TP may submit a request to the Broker.
All contracted TPs shall specify the reason(s) (i.e. repeated no shows, disruptive behavior) for which the Broker may request refusal to provide transportation services to a recipient. The Broker shall be required to demonstrate how the recipient's continued enrollment seriously impairs the TP's ability to furnish transportation services to the particular recipient. Contracted TPs shall submit to the Broker detailed documentation of a recipient's continued non-compliance with the TP's transportation guidelines. The Broker will review all detailed submissions and make a recommendation to EOHHS regarding a recipient's continued access to transportation services. All requests for disenrollment shall be made in writing to EOHHS for approval. TP is to continue to provide transportation services to the recipient until notified by EOHHS on the 834 file that the recipient has been removed.

3.10.1.4 Reimburse TPs

The Broker must reimburse TPs in a timely manner, utilizing an electronic billing system. The viability of a brokered network relies on professional business interactions between the Broker and the TPs. Details on TP payment requirements can be found in Section 4.5.6.

3.10.1.5 Process Retroactive Eligibility Claims

The Broker must establish a process to reimburse contracted and non-contracted TPs for stretcher, ALS and BLS transportation rendered to individuals that have Medicaid eligibility approved retroactively to the time service is rendered. The process shall include retroactive reimbursement for services up to ninety (90) days from the date of service. EOHHS must approve the process.

Capitated payments made to the Broker for recipients who are retroactively terminated due to death or disenrollment will be recovered by EOHHS.

3.10.1.6 Fulfill Trip Requests

The Broker must:

A. Fulfill all verified trip requests and ensure that all trips are completed safely and on time. EOHHS expects that the Broker will provide trip coverage twenty-four (24) hours a day, seven (7) days a week, and 365 days a year for the Medicaid program.
B. Include verification of the delivery of transportation services through the use of cost-effective methods and AVL tracking tools to determine the real-time location of the TP, of recipient delivery to the approved service, vehicle location and disposition and to aid in the trip recovery process.

3.10.1.7 Report Accidents, Injuries, and Incidents

The Broker must report to EOHHS all accidents, injuries, and incidents that have occurred in conjunction with a scheduled trip if a recipient is present in the vehicle. Accidents, injuries, and incidents shall be reported to EOHHS as follows:

(a) Accident/Incident with Injury: Notification within six (6) hours

(b) Accident/Incident without Injury: Notification within twenty-four (24) hours

The Broker employees and TPs are required to report any suspected cases of child, elder, or dependent adult abuse. Abuse may include physical, emotional, sexual, financial exploitation, or abandonment. Reporting should be made to:

(a) Department of Children, Youth and Families (DCYF) – 1-800-RI-CHILD
(b) Department of Elderly Affairs (DEA) – 401-462-0555
(c) Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) – 401-462-2629

3.10.1.8 Facilitate Trip Recovery

The Broker must ensure that each contracted TP is responsive to all vehicle breakdowns, problems, or delays in delivering transportation services and that either the contracted TP has adequate backup vehicles to recover the trips or the Broker has an adequate network of resources to recover the trips. The Broker must ensure that recipients are not late for their appointments and do not spend excessive time in the vehicles. EOHHS will closely monitor missed trips and

appointments through mandatory Broker reporting and will actively manage the Broker's performance.

3.10.1.9 Require Notification by Contracted TPs

The Broker must ensure that the contracted TP immediately informs the Broker of any breakdown, accident, or incident as well as any other problems that might cause a delay of more than ten (10) minutes. Immediately after the Broker is notified of a delay exceeding ten (10) minutes, the Broker shall also notify the recipients or their representatives and the facilities or families at the destination point. Other transportation shall be arranged to ensure timely transfer to appointments.

3.10.1.10 Maintain a Documented Hazardous Weather Plan

The Broker must maintain a documented effective and tested hazardous weather plan that describes how transportation services shall be provided for recipients in need of dialysis and other critical medical care during hazardous weather conditions such as, but not limited to, hurricanes, flooding, ice storms, tornado warnings or heavy snowfall. The Broker shall ensure that all contracted TPs maintain a documented hazardous weather plan consistent with the Broker's plan.

3.10.1.11 Maintain a Documented Communication Plan

The Broker must maintain a written communication plan that describes how the Broker will communicate with recipients, TPs, healthcare and facility providers, and EOHHS. The communication plan must be sufficiently detailed to enable EOHHS to determine that business communication with all stakeholders shall be performed in a logical sequence and in a timely manner. Each item or step listed in the communication plan shall include a description of the processes and protocols to be used to ensure timely, accurate and verifiable communication throughout the transportation enterprise. The communication plan shall include members' rights and responsibilities, how the members will be informed of changes in transportation arrangements, a process for member noncompliance and escalation procedures for conflict resolution between all stakeholders and the Broker. The escalation process shall include specific escalation procedures for members, TPs, healthcare and facility providers, and EOHHS. All member-facing materials and communication must be approved by EOHHS at least 30 days prior to being put into use. The Broker must take reasonable steps to provide meaningful access to all individuals with limited English proficiency.

3.10.1.12 Conduct Recipient Satisfaction Surveys

The Broker must conduct Recipient Satisfaction Surveys on a quarterly-basis to measure customer satisfaction. The Broker will submit the surveys for EOHHS approval prior to administering the surveys. The Broker will provide the raw survey data to EOHHS and the results will be summarized and reported to EOHHS on a quarterly-basis.

The Broker must describe, in detail, how they will conduct quarterly Recipient Satisfaction Surveys. The Broker should propose the method(s) they will use for the collection of this survey data and provide the survey to be used in the field to EOHHS for review no less than 30 days in advance. EOHHS expects each service population to be sampled on a quarterly basis.

3.10.1.13 Maintain Broker Websites, Mobile Applications & Other Innovations

The Broker must develop and maintain a website and mobile application to be used in the delivery of transportation. All content and functionality for the websites require EOHHS approval.

1) Provide an informational website, mobile application, and other innovations exclusively for the NEMT, TANF, and ETP programs. The website shall include the procedures required to request services, complaint and appeal procedures, riders' rights and responsibilities, and contact information. The website and applications shall be available to the public twenty-four (24) hours a day, seven (7) days a week, with the exception of EOHHS-approved downtime for maintenance. EOHHS shall be notified at least two (2) weeks prior to any scheduled outage or maintenance window. During the system outage, a notification page shall be displayed stating the system is undergoing maintenance and shall include the scheduled outage times. All content and functionality for websites require EOHHS approval.

2) Provide a secure website, with EOHHS-approved dashboards, that allows EOHHS to access, at minimum, all complaints, resolutions, trip assignments (by recipient or contracted TP) and the status of all trips (by recipient or contracted TP). The portal should give EOHHS access to databases and the ability to create customized reports. The portal must be approved by EOHHS prior to contract start date.

3) Provide a secure, interactive website that allows both recipients and healthcare providers/facilities the capability to request services. All requests for services received through the interactive website may require follow up communication with the requestor to ensure the service request contains complete and accurate information. The layout and content of the website shall be finalized with EOHHS approval.

4) Broker must require all contracted TPs to use AVL technology at all times. The information gathered through such technology should be utilized for scheduling trips, including recovery trips, and for verification of complaints, as applicable.

5) Broker should describe how they will use technology to improve performance, reduce cost and reduce no-shows.

3.10.2 CALL CENTER REQUIREMENTS

3.10.2.1 Call Center Operations General Requirements

The Broker shall locate the Customer Service Call Center in Rhode Island. The call center will be used to field transportation requests, assign trips and address trip concerns. The Call Center must have multi-lingual capabilities during a minimum of eight (8) continuous hours per day, Monday through Friday (Hours of Operation must be approved by EOHHS).

The Broker must also propose a Backup Call Center for business continuity purposes. The Backup Call Center may be located inside or outside of Rhode Island, but within the United States, and must be equipped to handle all the same services anytime that the main Customer Call Center is

closed. Key management staff must also be located in Rhode Island for ease of meeting with State staff, medical providers, facilities and other stakeholders.

During the contract, EOHHS may require the Broker to increase the number of telephone lines, depending on demand. The Broker must be able to mail letters to provider(s) and/or recipients upon request by the State at no additional cost to the State. A separate and direct office number is required for access by EOHHS staff.

The Broker shall utilize an automated method to schedule recipient trips once they are authorized and shall ensure that dispatching activities are performed efficiently. The scheduling method used must be capable of accommodating recurring trips, one-time trips, advance reservations, and requests for urgent trips. The Broker must describe their method of notifying recipients of trip times, and provide any additional information about the recipient's service needs to the drivers.

The Broker will comply with all Federal and State confidentiality policies and procedures in performance of the call center activities. The call center must respond to telephone and written inquiries from various sources such as MCOs/AEs and their representatives, healthcare providers, TPs, and other stakeholders.

3.10.2.2 Call Center Policies & Procedures

The Broker shall develop operations procedures, manuals, forms, and reports necessary for the efficient operation of the Call Center, which must be approved by EOHHS in writing at least 30 days prior to initial use. The Broker shall demonstrate the telephone system and staffing capability as requested by EOHHS.

3.10.2.3Call Center Responsibilities

The purpose of the call center is for the intake and processing of transportation needs for eligible recipients that includes, but is not limited to:

- Verification of transportation service eligibility;
- Ensuring that the transportation service offered is of last resort and there are no other means of personal or public transportation;
- Assessing recipient's transportation needs and determining the most cost-effective mode of transportation based on medical necessity;
- Authorizing transportation;
- Dispatching transportation trips;
- Resolving problems or disputes that may arise during a trip;
- Responding to reports of FWA;
- Responding to requests for general information and/or inquiries about transportation services;
- Providing information on other Transportation Programs such as RIPTA RIde and ADA services.

3.10.2.4 Call Center Staffing

The Broker shall hire sufficient staff to handle all calls and contacts for transportation related questions and problems that may occur. Staffing levels, as well as any staffing model or formula used to determine it, should be included in the proposal as described below. The Broker will also ensure that call center staff treat all callers with dignity and respect the caller's right to privacy and confidentiality. The Broker shall demonstrate their compliance through evidence provided to EOHHS.

The Call Center must have multi-lingual capabilities and the call center staff must have State approved training to respond to calls and inquiries from Broker, recipients and their representatives, healthcare providers, TPs, and other stakeholders. Training should include, but not be limited to, all transportation policies, call center procedures, cultural sensitivity training, confidentiality training, customer service skills and training for handling difficult callers.

The Broker will supply customer service representatives 365 days a year/24 hours a day/7 days a week. This includes the capacity to field calls after the call center has closed after normal business hours.

3.10.2.5 Call Center Staff Responsibilities

The Broker shall ensure that its Call Center staff and operators are capable of responding to telephone requests for information and that they respond to those requests in a timely manner. The Call Center staff and operators shall perform tasks including, but not limited to, the following:

A. Represent the Broker and EOHHS to the calling public;
B. Discuss the Program's main attributes courteously;
C. Provide prompt attention to the caller's needs;
D. Respect the caller's privacy during all communications and calls;
E. Maintain sensitivity to the diversity inherent in Rhode Island;
F. Maintain a professional demeanor at all times;
G. Assure the dissemination of accurate information to all callers;
H. Escalate calls from a dissatisfied recipient to a supervisor and on to a manager if satisfaction cannot be accomplished;
I. Document complaints or issues that are reported to the call center within the Call Center (i.e., late or missed pick up); and,
J. Transfer emergency transportation requests to 911 or another local emergency service.

3.10.2.6 Phone Lines and Equipment

The Broker shall supply a sufficient number of toll-free telephone lines to handle all calls 24 hours a day. For caller convenience and communication purposes a single toll-free telephone number must be used for the call center. The Broker must agree to relinquish ownership of the toll-free number to EOHHS upon contract termination.

Call flow routing and phone system queues must be reviewed by EOHHS. EOHHS may require additional queues with written notice to the Broker. The Broker shall obtain EOHHS approval prior to implementing any queue not required by EOHHS. The Broker shall provide a full description of the telephone system, including any specialized lines or routing to separately handle recipient and medical provider calls, as well as, an immediate trip problem resolution line.

3.10.2.7 Telephone Device for the Deaf (TDD)

The Broker shall maintain and operate a telephone device (TDD) for the deaf and hard of hearing callers who need such a device.

3.10.2.8 Automatic Call Distributor (ACD)

The Broker shall install and maintain a functioning Automatic Call Distributor (ACD) system and call reporting system that records and aggregates the following information, at a minimum, on an hourly, daily, weekly, and monthly basis, for the Call Center as a whole, and also for individual operators:

A. Total number of incoming calls;
B. Number of answered calls by Broker staff;
C. Average Speed Answered;
D. Percentage of calls answered in thirty (30) seconds;
E. Average talk time;
F. Number of calls placed on hold and the length of time on hold;
G. Number of abandoned calls and length of time until call is abandoned;
H. Number of outbound calls; and,
I. Number of available operators by time.

The Call Center performance will be measured against key indicators that are considered to be standard for the call center industry.

3.10.2.9 Reporting on Phone Calls

The Broker must examine data collected from its phone system as requested by EOHHS and as necessary to perform quality assurance and improvement, fulfill the reporting and monitoring requirements of the Contract, and ensure adequate staffing.

3.10.9.1 Call Tracking Requirements

A. 3.10.2.9.1.1 Identifying Information

The call center shall implement and maintain an automated call/contact management tracking system to track calls/contacts with basic identifying information.

B. 3.10.2.9.1.2 Online Display

The call center shall allow inquiry and online display of call/contact records by type, original call/contact date, caller's name, caller ID number, customer service correspondent name or ID, or any combination of these data elements.

3.10.2.9.2 Extraction and Reporting

The Broker will create EOHHS-defined extract files that contain summary information on all calls/contacts received during a specified timeframe.

The Broker will generate other reports as required by EOHHS. Reports and data must be available in the format specified by EOHHS with export and import functions.

3.10.2.10 Back-Up System

In the event of power failure or natural disaster, the Broker shall have a back-up system capable of operating the telephone system at full capacity, with no interruption of services or data collection. The Broker shall notify EOHHS when its phone system is on a back-up system or is inoperative. The Broker shall have a manual back-up procedure to allow requests to continue being processed if the system is down.

3.10.2.11 Call Center Performance Standards

The Broker shall perform the call center requirements to the following standards, which will be evaluated by EOHHS. (Refer to Section 4.5.15. for a full list of performance standards with associated liquidated damages.)

The Broker shall develop a process to measure and correct any deficiencies in call center performance.

3.10.3 TRANSPORTATION SERVICE AUTHORIZATION

3.10.3.1 Transportation Services Authorization

The Broker will develop policies and procedures for authorizing, scheduling, managing, and making payment for all transportation services. The actual transportation services under this RFP will be provided through subcontracts between the Broker and TPs. The Broker will be responsible for payment of transportation services furnished through subcontracts with TPs.

3.10.3.2 Recipient and Trip Eligibility Verification

The Broker must determine if the purpose of the request is to transport a recipient to a covered service. If the request is for a non-covered service, the Broker shall deny the request. A list of NEMT covered services is provided in Appendix V. This list is subject to change.

The Broker shall verify and document the eligibility of each recipient receiving transportation service provided under this Contract.

3.10.3.2.1 Pre-trip Review and Verification

The Broker shall verify the eligibility of each recipient requesting transportation by requiring one of the following:

- Verification from eligibility files and/or web portals supplied by RI State agencies
- Documentation from any authorized EOHHS staff

The Broker shall perform and document a pre-trip verification review by verifying the medical appointment for a covered service with the service provider on a minimum of 10 percent (10%) of scheduled trips prior to transportation services being provided.

3.10.3.2.2 Needs Test

The Broker shall verify that the recipient meets a needs test for transportation services. This is best done in the form of a "database script" which guides the process as an integral part of receiving a call from the recipient. The needs test shall include at a minimum:

- Verification from the requesting recipient that they have no other available means of transportation to/from destination.
- Verification that transportation is not covered by other programs or funding.
- Verification that the requested transportation is to/from an approved location.

3.10.3.2.3 Post-trip Review and Verification

The Broker shall perform and document a post trip verification review on a random minimum sample of ten percent (10%) of trips and include problem areas such as after-hours transportation; and verify that "routine trips" are for legitimate medical services.

3.10.3.3 Process Denial of Service Determinations

The Bidder should describe, in detail, its approach to: 1) the denial of service; 2) reduction in existing level of service or mode. The Bidder should include the method for denial or reduction determination and the standard process for communicating the determination to all recipients which includes the offer to appeal the denial of the service or mode/service level reduction by way of a Fair Hearing with EOHHS. The Bidder should include samples of all denial of or reduction in services/modes communications to be used by the Bidder.

The Broker shall include, in its reservation process, an objective and consistent method of correctly determining whether the request for services is approved, denied, or offered at a different mode or level of service. The process shall include call scripts and a list of corresponding codes available to the Customer Service Representative for coding denials or reduction in services.

The Broker will be responsible for submitting a monthly report in a format provided by EOHHS on all denials and reductions in mode or level of service, to include the number of requests for state Fair Hearing.

3.10.3.4 Process Trip Assignments

The Broker must detail its approach to processing trip assignments upon request for services. The process must describe the trip assignment tool(s) and trip routing processes the Broker will utilize to determine the least costly assignment of trips and to perform the transportation services under this contract. The Broker must explain features of the trip routing and trip assignment tool(s) and processes that will help drive a cost-effective program while meeting all contract service requirements. The Broker should demonstrate their capacity for determining the necessary assignment of trips that maximizes opportunities for the multi-loading of riders in vehicles while meeting or exceeding on-time performance measurements. The Broker should include a description of the multi-loading functionality in its routing and scheduling software, as well as describing how it will ensure TPs are multi-loading passengers to the extent possible.

The Broker must document whether the contracted TP accepts or declines the assigned trips. The Broker and contracted TP shall mutually agree upon a method of communicating trip referrals. If the contracted TP refuses the trip, the Broker shall immediately schedule the trip with another contracted TP and cancel the first. The Broker shall notify the recipient of the change in contracted TP. Once the trip is accepted by the contracted TP, the Broker shall not reassign the trip solely for

the convenience of the TP. The Broker shall monitor trips assigned to contracted TPs to ensure they are not over-booked. The Broker is required to monitor and report canceled and rerouted trips.

The Broker shall honor recipient choice of contracted TPs, to the extent possible based on TP availability, in the trip assignment process as long as the contracted TP is approved to provide the level of service and mode determined by the recipient's medical necessity. The Broker shall utilize a system to remind recipients of their scheduled trip 24 hours in advance. The Broker should explain how they plan on using technology such as SMS messaging to reduce wait time and no-shows.

3.10.3.5 Determine the Mode of Transport

The Broker shall authorize payment for the least costly mode of service available to meet the medical needs of the recipient.

3.10.3.6 Transportation Performance Standards

EOHHS and the Broker shall develop transportation performance standards during contract negotiations. Methods of measuring and reporting standards and applicable corrective actions shall be defined by EOHHS and the Broker.

3.10.4 TP NETWORK

The Broker must ensure it has the transportation network capacity to serve all eligible recipients.

The Broker must ensure its network is capable of meeting the following EOHHS requirements:

- Provide quality transportation service delivery to all eligible populations;
- Ensure that TPs are willing and able to serve all recipients including those with physical and mental challenges;
- Establish and incentivize a comprehensive transportation network that ensures that all recipients are served equally;
- Address TPs' challenges working in diverse home and geographical environments;
- Collaborate and communicate with the MCOs and to provide safe, timely and coordinated transportation;
- Focus on program integrity, FWA prevention and detection;
- Develop policies and procedures for authorizing, scheduling, managing, and making payment for transportation services;
- Subcontract with TPs and ensure access to high-quality transportation services.

3.10.4.1 TP Network Establishment

The Broker shall describe, in detail, their approach to establishing a sufficient TP network with the resources necessary (numbers and types of vehicles and drivers in each city or county) to deliver services to recipients. The Broker shall describe, in detail, their approach to establishing, implementing, operating, and maintaining an adequate network of contracted TPs that meet quality of service delivery and performance expectations. The Broker shall detail its TP selection criteria and procedures to verify the financial stability of all selected TPs.

The Broker shall describe, in detail, their contingency plans for unexpected peak transportation demands and back-up plans when notified that a vehicle is excessively late or is otherwise unavailable for service.

The Broker shall provide their procedures to ensure vehicle availability is adequate to fulfill the required standards of promptness and minimal ride time.

The Broker shall be responsible for identifying, recruiting, and negotiating sufficient service agreements with TPs to meet the needs of transportation recipients.

The Broker shall state if they propose to implement an incentive program for contracted TPs. If so, the Broker shall present the terms of the proposed incentive program, provide a detailed description of the proposed incentive program including how to fund the incentive program, and the type, content and frequency of incentive program reports that will be provided to EOHHS.

The Broker shall establish a network to ensure that recipients in the community are well served, including developing a competitive marketplace that has a variety of TPs for each mode of transportation.

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

EOHHS reserves the right to direct the Broker to terminate any service agreement with a TP when EOHHS determines this to be in the best interest of the State.

3.10.4.2 TP Contracts

The Broker shall detail its process for negotiating contracts with TPs. All contracts must be in writing. Broker must ensure that TPs are in compliance with all recipient protections. The Broker shall have a written plan for monitoring and oversight of performance of TPs, including provisions for assessing TP compliance and corrective actions and/or termination. Appendix VII details the terms EOHHS requires the Broker to include in its contracts with TPs. Broker is responsible for performance of all duties under this Contract and the State will consider the Broker to be the sole point of contact with regard to contractual matter. Bidder must submit sample contract.

The Broker shall maintain and make available all documentation for review by EOHHS staff on all contracts, including but not limited to each TP's business organizations, business licenses, certifications, insurance coverage, driver verifications, vehicle inspections, and all other relevant documentation, including payment rate structure upon request.

The Broker shall develop and implement a monitoring plan to monitor their contracted TPs to ensure compliance with the terms of their contracts. The HIPAA Privacy Rule requires that Broker obtain signed statement of HIPAA compliance from its TPs that will safeguard the protected health information they receive.

The Broker must maintain documentation for review by EOHHS staff on any TP's corrective action steps taken to ensure services provided are in compliance with this contract.

The Broker must ensure compliance with requirements of employer liability, worker's compensation, unemployment insurance, social security, and any other RI and local taxes applicable to the Broker and TPs.

The Broker shall encourage Minority and Women-owned Business Enterprises (M/WBEs) to become TPs. providing transportation services to EOHHS's Broker.

The Broker is expressly prohibited from establishing or maintaining contracts with TPs which have been convicted of Medicaid or Medicare fraud, or have been terminated from the Medicare or Medicaid program, or have been excluded from participation in any Rhode Island DHS or EOHHS Program.

The Broker must terminate a service agreement with a TP when unacceptable performance, as determined by EOHHS, is identified or the TP has failed to take satisfactory corrective action within a reasonable time period not to exceed (30) thirty days from the date of notice of the unacceptable performance. Broker must execute a written agreement with TPs that specifies the Broker's right to revoke the agreement and outlines reasons for a revocation of the agreement. Broker shall indemnify and hold EOHHS harmless as against any claim for damages or losses arising from services rendered by TPs in connection with the performance of this contract. The Broker shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against then Broker or subcontractor that, in the opinion of the Broker, may result in litigation related in any way to the Agreement with EOHHS.

3.10.5 TRANSPORTATION PROVIDER AND VEHICLE REQUIREMENTS

The Broker must provide a detailed approach to ensuring all drivers and vehicles providing transportation services under this contract meet the minimum requirements listed in this Section. These requirements shall be included in all contracts with TPs. With prior approval from EOHHS, the Broker may establish additional, non-conflicting requirements for drivers and vehicles.

The Broker must commit to the following requirements in delivering its broker services.

3.10.5.1 Ensure that all vehicles and drivers comply with the applicable laws, regulations, and ordinances of federal, state, and local agencies in the jurisdictions in which they operate, including public motor vehicle and taxicab authorities (RI PUC), and ambulance authorities (RI DOH).

3.10.5.2 Ensure all contracted TP vehicles/drivers have operational AVL capabilities.

3.10.5.3 Supply all contracted TPs with a copy of the Americans with Disabilities Act (ADA) vehicle requirements and inspect for compliance. Vehicles shall comply with the ADA Accessibility Specifications for Transportation vehicles, 49 CFR Part 38, Subparts A and B.

Vehicles shall be in compliance with applicable ADA vehicle requirements in order to be approved for use under this program.

3.10.5.4 Obtain and keep on file copies of required permits and licenses from the municipalities in which the contracted TP operates.

3.10.5.5 Ensure that all contracted TPs maintain a physical address in Rhode Island, are registered with the Rhode Island Secretary of State and maintain sufficient liability insurance as required by Rhode Island law and regulations.

3.10.5.6 Though a Broker may establish additional qualifications, the Broker must ensure the following minimum qualifications are met by all contracted individuals responsible for driving recipients under the terms of this RFP. All drivers at all times during their employment shall be at least eighteen (18) years of age and have a current valid driver's license to operate the transportation vehicle to which they are assigned;

(a) Drivers shall not have a driver's license suspension or revocation for moving traffic violations within the previous five (5) years;

(b) A criminal background check on each contracted driver through the RI Bureau of Criminal Identification (BCI) or the National Crime Information Center (NCIC) (if not a resident of Rhode Island for at least five (5) consecutive years), prior to employment and annually thereafter. For drivers not residing within the state of Rhode Island, criminal background checks equivalent to the BCI check from the driver's state of residence are also required;

(c) Drivers shall not have been convicted of any felony or misdemeanor related to healthcare fraud, patient abuse, child abuse, elderly abuse, criminal domestic violence, or criminal and/or sexual misconduct. A driver cannot be on any state or federal Sex Offender Registry. Within the last ten (10) years, drivers shall not have been convicted of any other felony crime. Within the last ten (10) years, drivers shall not have been convicted of any misdemeanor crimes for theft, embezzlement, breach of fiduciary responsibility, other financial misconduct, domestic violence, assault and battery, drugs, or weapons;

(d) All drivers shall be courteous, patient, and helpful to all passengers and be neat and clean in appearance;

(e) No driver shall be under the influence of or use alcohol, narcotics, or illegal drugs while on duty. No driver shall use prescription or nonprescription medications or other substances that may impair the driver's ability to perform while on duty.

(f) All contracted TPs shall implement a verifiable 5-panel drug-testing program for drivers. Pre-employment, post-accident, and random drug screens covering more than twenty-five percent (25%) of the drivers each year shall be mandatory;

(g) All drivers shall wear and have a visible nametag, with picture, that is easily readable and identifies the employee and the employer. The driver shall show the nametag to the recipient or facility employee upon arrival to pick up the recipient;

(h) All contracted drivers must have their PUC identification visible during operation of their vehicle;

(i) Drivers are required to affix the EOHHS Transportation Vendor sign to the side of the vehicle when in use for the transportation of recipients identified in the contract.

(j) Drivers shall not smoke (this includes e-cigarettes and non-combustible Tabaco product) or use tobacco of any kind while in the vehicle, while assisting a recipient or while in the presence of any recipient;

(k) Eating is prohibited in all vehicles while transporting recipients;

(l) Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones if this is the company communication device;

(m) Drivers shall not text or use a computer/tablet while driving;

(n) For door-to-door level of service drivers shall identify themselves, show their identification and announce their presence at the entrance of the facility or residence;

(o) Drivers shall assist recipients in the process of being seated and confirm that all seat belts are fastened properly;

(p) Drivers shall ensure recipients in wheelchairs are properly secured to the vehicle and/or wheelchairs are properly secured to vehicle prior to departure and at all times while in transit;

(q) Drivers shall ensure that children are secured in a child safety seat compliant with the RI Department of Public Safety Transportation guidelines for infant and child safety seats, as necessary; and adult escort if responsible for the car seat;

(r) US Department of Transportation-approved age-appropriate child restraint system (car/booster seat) prior to departure and at all times while in transit;

(s) Drivers shall provide necessary assistance, support, and verbal instructions to passengers. Such assistance shall include whatever is necessary for recipients with limited mobility as well as movement and storage of mobility aids and wheelchairs;

(t) Before departing the drop-off point, drivers shall confirm that the recipients are safely inside their destination;

(u) Drivers shall not touch any recipient except as appropriate and necessary to assist the recipient into or out of the vehicle, into a seat, to secure the seat belt, or to render first aid or assistance for which the driver has been trained;

(v) Drivers shall not solicit or accept money (except for co-pay requirements), goods or additional business from recipients;

(w) Drivers shall be familiar with the streets and highways of the areas in which they are transporting; and,

(x) Drivers shall follow company and Broker guidelines for HIPAA compliance by keeping all recipients' protected health information (PHI) confidential. It should not be visible to other recipients/passengers, and drivers shall not discuss this information with anyone who is not involved with the recipient's treatment or healthcare services.

3.10.5.7 Conduct all driver credential reviews prior to implementation, prior to the driver transporting recipients, and at least annually thereafter.

3.10.5.8 Ensure that all drivers complete and maintain the following EOHHS approved training and/or certification:

(a) Cardiopulmonary Resuscitation (CPR);

(b) First Aid;

(c) Defensive Driver;

(d) Passenger Assistance – transferring, loading, unloading;

(e) HIPAA Compliance; and

(f) Cultural competence training

(g) Participate in a minimum of twelve (12) hours in-service training on related subjects annually, including training on working with special populations such as disabled and/or elderly.

3.10.5.9 Ensure that the contracted TP terminates any driver from the transportation program when substandard performance is identified, as documented by the Broker or at the request of EOHHS. EOHHS reserves the right to direct the Broker to terminate any driver when EOHHS determines it to be in the best interest of the State.

3.10.5.10 The Broker must ensure all TP owners, drivers, and employees are not debarred, suspended, or otherwise excluded from participating in procurement activities under sections 1128(a)(1), 1932(d)(1) and 42 CFR 438.610 at the time of hire and thereafter. A searchable database of persons excluded can be found http://exclusions.oig.hhs.gov/.

3.10.5.11 Ensure all vehicles pass the Broker inspection prior to transporting recipients. Bidder shall provide criteria for inspection to EOHHS. The Broker shall inspect all vehicles transporting recipients annually and ensure all vehicles transporting recipients meet the following requirements:

(a) The TP shall provide and use a two-way voice communication system (mobile telephone or two-way radio) linking all vehicles used in delivering the services under this contract with the contracted TP's place of business. Pagers are not an acceptable substitute;

(b) All vehicles shall be equipped with adequate and functioning heating and air-conditioning systems. Functionality shall be defined by temperature readings from the rear of the vehicle, achieving air conditioning to sixty-eight (68) degrees and heating to seventy-two (72) degrees;

(c) All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position and securement belts for each wheelchair position; step stool should be available if needed.

(d) Each vehicle shall comply with all RI Department of Public Safety Transportation guidelines for infant and child safety seats, as necessary when transporting children; and adult escort if responsible for the car seat;

(e) Each vehicle shall have at least two (2) functional seat belt extensions available;

(f) Each vehicle shall be equipped with at least one (1) seat belt cutter within easy reach of the driver. Exceptions to this requirement shall be approved in advance by EOHHS;

(g) All vehicles shall have an accurate speedometer and odometer;

(h) All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment;

(i) The exterior of the vehicle shall be clean, free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicle;

(j) The interior of the vehicle shall be clean, free from torn upholstery, floor, or ceiling covering; free from damaged or broken seats; and free from protruding sharp edges. The interior shall also be free of dirt, oil, grease, and litter;

(k) Vehicles shall be free of hazardous debris or unsecured items and shall be operated within the manufacturer's safe operating standards at all times;

(l) To comply with HIPAA requirements, the word "Medicaid" may not be displayed on the vehicle or in the name of the business;

(m) The vehicle license number, the Broker's toll-free phone number and a local phone number for the Broker shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format in each vehicle for distribution to recipients upon request;

(n) All public motor vehicles (PMVs) used in the transportation network must have EOHHS-approved visible signage identifying the vehicle as part of the transportation system. All contracted drivers must have their PUC identification visible.

(o) All vehicles shall have the following signs inn English and Spanish, posted in all vehicle interiors, easily visible to the passengers:

- "NO SMOKING (TOBACCO PRODUCTS or E-CIGS)"
- "ALL PASSENGERS MUST USE SEAT BELTS"

(p) Vehicles shall carry an information packet containing vehicle registration, insurance card, a copy of the form used for the latest Broker inspection, and accident procedures and forms;

(q) Vehicles shall be equipped with a first aid kit;

(r) Vehicles used for the transportation of recipients shall include GPS systems, which at a minimum, are capable of recalling the location of the vehicle for specific periods of time; and,

(s) Insurance coverage for all vehicles shall be in force at all times during the contract period in accordance with state and local regulations and contract requirements.

3.10.5.12 Broker must record and maintain a file of all vehicles inspected by the Broker and the file must be available upon request.

3.10.5.13 Remove from service immediately any vehicle or driver found out of compliance with these contract requirements or any applicable state or federal regulations. Once the Broker verifies

and documents that the deficiencies have been corrected, the vehicle or driver may be reinstated. Any deficiencies and actions taken must be documented and become a part of the vehicle's and the driver's permanent records.

3.10.5.14 Ensure TPs comply with the following passenger safety requirements:

(a) Passengers shall have their seat belts buckled at all times while they are inside the vehicle. The driver shall assist passengers who are unable to fasten their own seat belts if requested;

(b) The driver shall not start the vehicle until all passenger seat belts have been buckled;

(c) The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity;

(d) Upon arrival at the destination, the vehicle shall be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination;

(e) Drivers shall not leave passengers unattended and

(f) If passenger behavior or other conditions impede the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic and notify their dispatcher or 911 to request assistance.

3.10.5.15 Provide stretcher van service, ALS and BLS to Medicaid eligible recipients as an alternative mode of transportation for pre-authorized trips consistent with EOHHS policy. Stretcher service is provided to an individual who cannot be transported in an ambulatory or wheelchair van, and who does not need the medical services of an ambulance. Stretcher van service does not provide emergency medical transport and does not include any medical monitoring, medical aid, medical care, or medical treatment during transport. A driver and an assistant shall staff the vehicle, which is specifically designed and equipped to provide transportation of individuals on an approved stretcher. A stretcher van is used for an individual who:

(a) Needs routine transportation to or from a non-emergency medical appointment or service;

(b) Is convalescent or otherwise non-ambulatory and cannot use a wheelchair; and does not require medical monitoring, medical aid, medical care, or medical treatment during transport.

3.10.6 PAYMENT TO TPS

The Broker is responsible for TP reimbursement. The Broker is responsible for validation that transportation services reimbursed are properly authorized and actually rendered to eligible recipients. A successful TP network is predicated on the delivery of professional transportation services with timely reimbursement for those services.

The Bidder should provide a detailed description of the process it will use to reimburse TPs for transportation services through an electronic billing system. The Bidder shall describe the process for compliance with federal and state prompt payment provisions that require claims payment timeliness standards and processes to resolve late, incomplete, or disputed claims. Full payment of undisputed claims for all authorized trips must be made to the TPs as agreed upon between the

parties through a written term of service agreement. The Broker must demonstrate its ability to resolve crossover Medicare/Medicaid claims as well as any other coordination of benefits situation in a timely manner. The Bidder must provide a description of the payment policy for late and/or no-show TPs.

EOHHS seeks a Broker with a pro-active approach to managing claims issues in a timely and efficient manner.

3.10.6.1 Claims Processing Responsibilities

The Broker shall meet the following claims processing timeliness standards.

Provide payment to each TP based on authorized services rendered. The Broker shall pay contracted TPs in accordance with the terms of the contract between the Broker and each TP.

3.10.6.1.1 Make full payment for ninety-five percent (95%) of undisputed invoices for authorized trips to the contracted TPs within thirty (30) calendar days of the Broker's receipt of an undisputed invoice.

3.10.6.1.2 Make full payment on a minimum ninety-nine percent (99%) of undisputed invoices for all authorized trips within sixty (60) calendar days of the date of receipt.

3.10.6.1.3 Non-clean claims must be adjudicated within twenty-four (24) calendar days of the date of correction of the condition that caused the claim to be non-clean.

3.10.6.1.4 All claims must be adjudicated within twelve (12) months of receipt by the Broker, except for those exempted from this requirement by Federal timely claims processing regulations as cited in the Federal regulations at 42 C.F.R. Part 447.45.

3.10.6.1.5 All TP billing adjustments must be processed for payment or denied within thirty (30) calendar days of receipt by the Broker.

3.10.6.1.6 All notifications of payment denial must be communicated via mail by the Broker to the TP during the regular payment cycle.

3.10.6.1.7 Those circumstances when claim resolution is being handled directly by State staff in accordance with State guidelines or held by the Broker under State written directive shall not be counted in the calendar day threshold. All claims received regardless of submission method must be assigned an Internal Control Number by the Broker.

3.10.6.1.8 A different timely filing limit will be established for Medicare cross over claims and COB claims to ensure TPs are not penalized due to the delay in claim submission created by waiting for a response from the primary payer.

3.10.6.2 The Broker shall:

(a) Validate that all services paid for were properly authorized and actually rendered;

(b) Transmit to EOHHS encounter data for all trips made for Medicaid recipients in accordance with EOHHS specifications;

(c) Develop safeguards against fraudulent activity by the contracted TPs and recipients and fulfill EOHHS reporting requirements regarding such activity. The Broker shall report all suspected FWA incidents within the time frames detailed in Section 4.5.8.1 of this RFP. Broker shall submit monthly FWA reports. Reports shall include (1) the number of complaints of FWA that warrant preliminary investigation, and (2) for each case of suspected TP FWA that warrants a full investigation the reports will include at a minimum:

- The TP's name
- The source of the complaint
- The nature of the complaint
- Approximate monetary value resulting from the fraudulent activity
- Legal and administrative disposition of the case including any actions taken by law enforcement officials to whom the case was referred
- The mode of transportation

(d) Provide reports to EOHHS upon request summarizing the claims payment processing that will include but is not limited to, the number of days for claim payment and the number of days between services rendered and the submission of claims to be paid.

3.10.7 EDUCATION PROGRAM

The Broker should provide a detailed description of the training/outreach events and related materials that it will utilize to ensure contracted TPs, healthcare providers and facilities understand their responsibilities. The broker should also provide the rules and any changes related to reservations, service delivery expectations, any policies or procedures, billing procedures, reimbursement methodology, penalties and incentives, identification of FWA and the overall human service transportation program structure. The broker should also include a list and detailed description of all communication materials for contracted TPs, healthcare and facility providers and eligible transportation populations.

The Broker should include how ongoing education throughout the life of the contract will be conducted by the Broker for medical providers, TPs, and recipients.

The Broker is responsible for developing transportation service marketing materials, subject to EOHHS approval, at least 30 days in advance of use. Plan materials developed or distributed by TPs also require EOHHS review and approval before being distributed. These marketing materials should be used to educate recipients about the availability of transportation services and the process to access them.

3.10.7.1 Education Responsibilities

The Broker shall:

Develop and organize training events and training materials to ensure contracted TPs, healthcare providers, and facilities who access the system on behalf of the recipient understand their

responsibilities, rules associated with transportation reservations, service delivery expectations, changes related to any policies or procedures, billing procedures, reimbursement methodology, penalties and incentives, and the overall transportation program structure. All such training materials must be supplied to EOHHS and approved in advance of trainings. The cost of any mailings is to be borne by the Broker and shall be provided for as an administrative expense.

Detail how ongoing education will be conducted by the Broker:

Provide a training program for all contracted TPs. At a minimum, the training program shall include:

(a) Overview of the EOHHS Transportation Programs and division of responsibilities between Broker and TP;

(b) Emphasize the importance of providing culturally-sensitive services to recipients

(c) Broker shall purchase and provide educational information for consumers related to utilization of the transportation services. All consumer directed materials must be reviewed and approved 30 days in advance by EOHHS. Educational/consumer materials will be the Broker's responsibility to fund and distribute.

(d) Vehicle requirements, to include GPS tracking equipment and use;

(e) Procedures for handling accidents, moving violations and vehicle breakdowns;

(f) Driver qualifications;

(g) Driver conduct;

(h) The use of escorts and/or companions;

(i) Scheduling procedures during regular operating hours, including criteria for determining the correct mode of transportation based on the recipient's medical necessity;

(j) "After hours" scheduling procedures;

(k) Procedures for handling requests for "urgent care";

(l) Criteria for trip assignment;

(m) Dispatching and delivery of services;

(n) Procedures for obtaining reimbursement for authorized trips;

(o) Driver customer service standards and requirements during pickup, transport, and delivery;

(p) A review of the TP manual;

(q) Required communication with Broker;

(r) Required communication with healthcare providers;

(s) Billing Procedures;

(t) Record keeping and documentation requirements for scheduling, dispatching and driver personnel, including completion of required logs;

(u) HIPAA compliance requirements;

(v) Financial stability requirements;

(w) Procedures for handling complaints from Broker or TPs;

(x) Hazardous weather policy;

(y) Emergency contingency procedures;

(z) Disaster recovery procedure.

(aa) Code of conduct to include FWA

TPs must provide documentation to Broker that all their divers completed required training.

3.10.8 COMPLAINTS & APPEALS

The accurate administration of an integral complaint process is essential to EOHHS in ensuring the integrity of the Broker's services. The Broker must describe, in detail, their standard complaint process and approach to handling complaints, whether verbal or written, from recipients, TPs, healthcare providers and other facilities, EOHHS, other interested parties or the Broker itself. This should include written procedures and processes that will be used by the Broker to receive and respond to all complaints about transportation services and the use of technology to aid in determining the validity of complaints. In addition, EOHHS seeks access to a real-time dashboard reporting tool to ensure effective complaint monitoring and resolution.

The Broker should clearly define its processes to effectively manage and positively respond to complaints. EOHHS seeks a Broker with a demonstrated ability to implement corrective actions based on valid complaints and employ strategies to improve overall service satisfaction.

Recipients have a right to appeal any action taken whereby services are denied or reduced in any way. The Broker is required to provide the recipient with a Notice of Action in writing and must explain:

- The action the Broker, or its agents, has taken or intends to take
- The reasons for the action
- The recipient's right to file an appeal with EOHHS for a State Fair Hearing
- The recipient's right to a State Fair Hearing
- The procedures for exercising the rights in this section

Broker must mail the notice of action to the recipient within the timeframes specified in 42 CFR 438.404. The Broker shall also meet the requirements in 42. CFR 438.10 regarding information provided to recipients.

EOHHS will establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. The Broker must make verbal

interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the State, as well as large print (18 point), explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a). This must be added to any letter they may use that explains recipient's right to the State Fair Hearing process as a result of having their level of service decreased or denied.

The Broker shall make interpretation services available to each member and make those services available free of charge to each recipient. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

Written materials must use easily understood language. The Broker must ensure that recipients are informed that alternative formats are available for those with special needs who may be visually limited or have limited English proficiency. All written materials for recipients must include taglines in the prevalent non-English languages in the State, as well as large print (18 point), explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free telephone number to call for assistance as required by 42 CFR 438.71(a). All recipients must be informed that information is available in alternative formats and how to access those formats. Verbal interpretations must be available to recipients in all languages.

Recipients need to be properly informed of the complaint process and how to escalate issues of concern.

3.10.8.1 Complaint & Appeal Management Process

The Broker shall:

- Receive and respond to all complaints and requests for appeals about transportation services under this contract, whether verbal or written, from recipients, TPs, healthcare providers, facilities, EOHHS or other sources. While appeals are forwarded to EOHHS to be managed as a State Fair Hearing, The Broker may assist the members in gaining resolution prior to the Hearing Office acting on the appeal. The Broker may assist the member in accessing and completing the State Fair Hearing request form.

- Respond verbally to all parties directly involved within twenty-four (24) hours of receipt of a complaint or appeal. The Broker shall respond in writing within seventy-two (72) hours. Complaints regarding transportation services referred to the Broker by EOHHS for resolution require a written response from the Broker to EOHHS within the timeframe requested by EOHHS, but no more than three (3) business days after receipt of the complaint.

- Report complaints to EOHHS via secure e-mail or other EOHHS-approved method in the time frames indicated below. The time frames refer to the amount of time from the time the Broker receives notice of incident/complaint.
    - Tier One complaints (see definitions section) – within 6 hours
    - Tier Two complaints (see definitions section) – within 24 hours

- Tier Three complaints (see definition section) – complaints to be included in monthly reports
- Reported/Suspected FWA:
  - To be included on monthly reports
  - Must be submitted to EOHHS Program Integrity within 48 hours

- Establish and maintain a standard complaint and appeal process for handling all complaints that includes the requirements for maintaining documentation of all activity related to recording, investigating and the resolution of complaints and appeals.

- Record all complaints for TP no shows and verify them all with GPS/AVL Technology regardless of the source. Handle the complaint using the Broker's standard complaint process.

- Include in the standard complaint process an initial review of the complaint to verify the complaint has merit, verify that it has been filed with the appropriate party, and that an initial severity for the complaint is determined and recorded. Investigations shall include obtaining enough factual information about the complaint by all available means including tracking technology to determine the appropriate response and corrective action required. Complaints shall be resolved and closed within five (5) business days. For any complaints requiring additional time to resolve, the Broker shall provide EOHHS with daily updates until resolved.

  - Complaints that are found to be unsubstantiated after the initial review shall be reviewed by a supervisor or above to confirm the initial disposition.

  - Complaints that are determined to be high priority based on the nature of the complaint shall require immediate attention by a supervisor or above for resolution.

- Maintain an electronic record of all complaints, verbal and written, with documentation of the complaint and the actions taken to resolve the complaint. Maintain an electronic record of all requests for State Fair Hearings with any supporting documentation. The Broker shall send a report to EOHHS of all complaints and appeals received and their resolution, including any corrective action taken, on or before the fifteenth (15$^{)}$ day of the month for the previous month's activity (for example, reports for activity in March will be due by April 15th). The report must be in accordance with the specifications and format approved by EOHHS. The Broker shall compile a summary report which analyzes all complaints and appeals received on a monthly basis to determine the quality of services, noting any patterns or trends of the complaints or appeals received. The Broker shall analyze the complaint and appeal data as an integral part of its TP monitoring for quality improvement.

- Develop a complaint response process that includes the following key features:
  - The appropriate entities are contacted for a response to the complaint;
  - The dispositions of all complaints are communicated to the initiating entity;
  - The dispositions of substantiated complaints are communicated to the entity the complaint is logged against;
  - Corrective action required based on the complaint is verified to have been implemented; and

- Complaints are closed appropriately and all entities are notified of the final disposition of the complaint.

- Develop an appeal process that includes the following key features:
  - Provision of a written copy of the adverse determination or action that contains:
  - The DHS 121 form to file an appeal;
  - Offer of assistance to help complete the form;
  - Inform the recipient that they may act on their own behalf or permit someone else to act for them;
  - Explain that they can get free legal help at RI Legal Service www.helprilaw.org (401.274.2652);
  - Offer to provide the letter in another language or format; including verbal interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.
  - Provide contact information of someone who can answer any questions;
  - Inform the recipient that they have 120 days to file an appeal which can be done in the following ways:
    - Call 401-462-2132 (TDD 401-462-3363)
    - Fax to 401-462-0458
    - Email to OHHS.AppealsOffice@ohhs.ri.gov
    - Mail to:

      EOHHS
      Virks Building
      3 West Road
      Cranston, RI 02920
  - Maintain a file for each appeal that must contain, at a minimum, all of the following information:
    - A general description of the reason for the appeal.
    - The date received.
    - The date of each review or, if applicable, review meeting.
    - Resolution of appeal, if applicable.
    - Date of resolution at each level, if applicable.
    - Name of the recipient for whom the appeal was filed.
    - The record must be accurately maintained in a manner accessible to EOHHS and available upon request to CMS.

- Close complaints only after appropriate action is taken to resolve the complaint. The close process must include documented communication to the entity initiating the complaint and the entity the complaint was logged against to include any corrective action taken and the final disposition of the complaint. Complaints that are not closed within five (5) business days shall require notification within 24 hours of the end of the business day to EOHHS.

- Accurately record all complaints and the activity taken to investigate the underlying cause of the complaint as well as the immediate action taken to resolve the complaint. At a minimum, the complaints tracked and reported must include the list in 4.5.10.1.4.
  1.
- Service Complaints and Appeals guidance can be found in Appendix VIII.

3.10.9 QUALITY ASSURANCE

The Broker must provide its overall approach to providing a quality service delivery. The Broker must ensure that it has an ongoing quality assessment and performance improvement program for its services. The Broker must develop criteria and procedures to provide for systematic activities and analytics, undertaken by the Broker itself, to monitor and evaluate the services rendered according to predetermined, objective standards.

3.10.9.1 Quality Improvement & Operations Plan

This approach must include a Quality Improvement & Operations Plan to be used by the Broker in its transportation service delivery. The Broker must include how it proposes to monitor and evaluate its provision of transportation services, and the inclusion of a Performance/Process Improvement Program. The Quality Improvement & Operations Plan must be updated and provided to EOHHS at least on an annual basis.

The plan must ensure that provided services are of the highest quality and that improvements are being made. It should support a vendor business culture that includes comprehensive quality assurance and quality improvement activities and an organized, strategic plan to identify opportunities for improvement on an ongoing basis.

The Plan shall include, at a minimum the following elements:

(a) Key indicators of quality related to scheduling and delivery of services;

(b) A description of how the Broker plans to monitor these key indicators;

(c) A description of how the Broker will develop, implement, and evaluate corrective actions or modifications to overall operations as necessary to address quality concerns;

(d) A description of how the Broker will monitor the quality of services and the efficiency of its processes;

(e) A description of the staffing resources responsible for the plan and quality improvement activities; and

(f) Samples of all reports related to quality assurance and performance monitoring, along with descriptions of their use and who is responsible for reviewing them.

3.10.9.2 Quality Improvement & Operations Plan Submittal

An initial plan must be submitted in the response to this RFP. A final plan must be submitted to EOHHS for review and approval at least thirty (30) working days prior to the start of operations. The Broker must incorporate any modifications, which EOHHS requires, within ten (10) working days of notification. In no case will the Broker be allowed to begin operations without an approved plan. Thereafter, the plan must be formally evaluated at least annually and the findings, as well as any revisions, submitted to EOHHS for review and approval at least thirty (30) days prior to implementation.

3.10.9.3 Quality Assurance Activities & Monitoring

3.10.9.3.1 The Broker must establish, implement, and maintain corrective action plans addressing findings resulting from complaints, Federal or State reviews, or other reviews conducted during the term of the contract. The Broker shall implement corrective action plans based on a root-cause analysis in accordance with time frames established by EOHHS.

3.10.9.3.2 The Broker must maintain documented standards for the selection and retention of TPs that include quality of service expectations.

3.10.9.3.3 The Broker must provide assurance that contracted TPs meet health and safety standards for vehicle maintenance, operation, and inspection; driver qualifications and training; recipient problem and complaint resolution; and the delivery of courteous, safe, and timely transportation services.

3.10.9.3.4 Develop criteria and procedures to provide for systematic activities and analytics, undertaken by the Broker itself, to monitor and evaluate the transportation services rendered according to predetermined, objective standards, and affect improvements as needed.

3.10.9.3.5 Make available to EOHHS all of the contracted TP's vehicles for monitoring and inspection at any time. EOHHS monitoring activities will not interfere with the Broker's responsibility to provide transportation to recipients. EOHHS staff may ride on trips to monitor service. EOHHS staff shall review reports of complaints from recipients, TPs, or any individual or group who contact the Broker regarding the delivery of transportation services under this contract.

3.10.9.3.6 Meet with EOHHS representatives at EOHHS offices at least monthly and upon request by EOHHS to discuss the program and to answer pertinent inquiries regarding the program, its implementation, and its operation.

3.10.9.3.7 Be required to provide representation on transportation related committees and boards and participate in scheduled meetings.

3.10.10 MANAGEMENT AND PERFORMANCE REPORTS

The Bidder shall describe its proposed plans for generating all of the required reports as well as development of any ad hoc reports required by EOHHS. The Bidder in responding to this RFP must provide samples of all management and performance reports to be produced under this

contract. The Broker shall establish and maintain a database capable of providing monthly utilization data to EOHHS.

The Broker must submit accurate and complete management reports to EOHHS at requested intervals and on demand using electronic media, as approved by EOHHS. All underlying calculations for reporting shall be submitted to EOHHS for review and approval. Monthly reports shall be due on the fifteenth day of the month for the previous month's activity (for example, reports for activity in March will be due by April 15th), in a format prescribed by EOHHS.

The Broker shall provide accurate and complete management reports by reporting deadlines accompanied by the EOHHS provided attestation. Failure to provide accurate and complete management reports by reporting deadlines may result in liquidated damages. All year-to-date (YTD) reports generated by the Broker for transportation services shall be based upon Rhode Island's State Fiscal Year. The state's fiscal year begins July 1st and ends June 30th.

3.10.10.1 Mandatory Reports

The Broker shall provide EOHHS with the report templates specified below prior to the Implementation/Operation Start Date. Report formats may include paper reports or data files. Broker shall provide additional reports or make revisions in the data elements or format upon the request of EOHHS, without additional charge to the EOHHS and without a contract amendment. Upon request of EOHHS, the Broker shall supply the underlying data to support any report submitted. The data shall be in a mutually agreed upon electronic file format. EOHHS may add or delete reports to be submitted without requiring a contract amendment. Failure to meet the timeliness standard set forth for each report may, in the sole discretion of EOHHS; result in the assessment of liquidated damages.

The Broker shall provide, at a minimum, the following management reports to EOHHS.

3.10.10.1.1 TP Monthly Report Card: The report shall detail the following by the TP:

(a) Total trips (less cancellations) assigned to the TP;

(b) Total number of trips for which the TP is late;

(c) Total number of trips for which the TP is a No Show; and

(d) Total number of complaints for which the TP is at fault.

The report shall compute the percentage of trips run complaint free and the percentage of A-leg trips that were completed on-time.

3.10.10.1.2 Call Center Report: The Broker shall submit a customer services center report monthly that identifies the telephone data for the normal business hours (Monday through Friday):

(1) Total number of calls received

(2) Number of phone calls abandoned, listed by:

(a) Incoming

(b) From queue

(c) Average time to abandon

(3) Average Speed to Answer (ASA).

(4) Total number of calls completed (answered by an agent).

(5) Average call length.

(6) Average after-call work time.

(7) Average number of daily phone calls received.

(8) The amount of telephone system inoperable time, in excess of one (1) hour, per incident.

(9) Percentage of calls answered within 30 seconds

3.10.10.1.3 Transportation Data Report: The Broker shall submit transportation data for each program that identifies the following at minimum:

a) Number of trips scheduled
    a. By mass transit
    b. By mileage reimbursement
    c. By other modes
b) Number of trips provided – <u>do not include mass transit</u>
    a. By mode
    b. By destination type
    c. By dollar cost
    d. By each TP
        i. Total dollar cost
        ii. By mode
    e. By standing-order
c) Number of trips cancelled or cancelled and rescheduled – <u>do not include mass transit</u>
    a. By recipient
    b. By provider
    c. With 24 hour notice or more
    d. With less than 24 hour notice
d) Number of trips denied by reason denied
e) Unduplicated number of recipients served
    a. By reporting month
    b. By fiscal year cumulative total
f) Unduplicated number of recipients served excluding mass transit and mileage reimbursement
    a. By reporting month
    b. By fiscal year cumulative total
g) List of the "most-costly" recipients
h) The percentage of trip verifications. Provide summary information detailing any improprieties that were discovered and the efforts taken to correct them.
    a. Pre-trip
    b. Post-trip

i) Number of no-shows
    a. By recipients
j) The rates table for all TPs
k) The number of letters sent to recipients informing them of a reduction in the level of service or mode of service
l) The number of appeals received

3.10.10.1.4 Complaint Report. The Broker shall submit complaint data that identifies at minimum:

a) The number and percentage of complaints compared to total number of trips provided (not including mass transit)
b) Complaints by category reported by complainant type and complained against type including at minimum:
    a. Criminal
    b. Suspected FWA
        i. Recipient
        ii. TP
        iii. Other
    c. Harassment (including sexual harassment)
    d. Incident
        i. Rider
        ii. TP
        iii. Other
    e. Injury
    f. Negligence
    g. Accident
        i. With injury
        ii. Without injury
    h. Wheelchair/equipment tie-down issues
    i. Resolution of complaint
c) Additional information including, but not limited to, specific complaints as determined by EOHHS.
d) Reporting template must be approved by EOHHS prior to start of contract.

3.10.10.1.5 MWBE Report. The Broker shall submit MWBE Data that documents the level of business done with Minority and Women-Owned Business Enterprises (MWBE), including but not limited to:

a. All business relationships, not just transportation.
b. Efforts to encourage MWBE participation in the EOHHS Transportation Program.

3.10.10.1.6 Quality Assurance Report. The Broker shall submit a Quality Assurance Report that summarizes information collected from the Quality Assurance plan and describes how the information will be used to improve services. Included in this report are the results from Call Quality Monitoring activities conducted on all call center staff who answer the telephone.

3.10.10.1.7 Quarterly Program Integrity Report. The Broker shall submit a Quarterly Program Integrity Report that summarizes potential recipient and TP fraud, waste, and abuse cases. EOHHS will work with the Broker to formalize the reporting template.

3.10.10.1.8 Monthly Encounter Submission. The Broker shall submit encounter data on a monthly basis in the format specified by EOHHS.

3.10.10.1.9 Other Reporting Requirements. The Broker shall deliver to EOHHS any records within five (5) business days if requested by EOHHS in writing. If EOHHS requests that such records be submitted in a specific format, the delivery date to EOHHS will be negotiated.

3.10.11 RECORDS RETENTION

The Broker must employ a detailed system to ensure all programmatic data is properly recorded and retained consistent with applicable state and federal laws and regulations. The Broker must maintain records and supporting data (including but not limited to recipient data, trip authorizations, claims data and TP records) in a retrieval and storage mechanism that complies with all Federal and State requirements for a time period that complies with State and Federal record retention requirements which are ten (10) years for medical records, source records and financial records and seven (7) years for litigation. Failure to maintain all required documentation or to provide such records to EOHHS upon request may result in the disallowance and recovery by EOHHS of any amounts paid for which the required documentation is not maintained or provided.

The Broker must:

- Record authorization data in a computerized format, including the name of recipient, recipient Medicaid ID number, date of birth, pick-up address and telephone number, date of service request, name and telephone number of person requesting transportation services, reason for transport, date and time of appointment, and the name and address of the medical provider or facility to which transportation services are requested. All records pertaining to the contract must be housed at, or accessible from, the designated business office, approved by EOHHS and readily available for review at the request of EOHHS or its authorized representatives.

- Maintain a computerized daily log of all calls received and trips scheduled, including approved and denied requests. Approved transportation requests shall be logged by trip number; denied requests shall be logged in chronological order.

- Establish, maintain, and provide, upon request, any records listed in the vehicle and driver requirement section of this RFP.

- Maintain the original authorization for transportation services, to include the trip dispatch/passenger log, Recipient record and mileage verification reporting from a computerized route mapping tool. EOHHS shall monitor and review eligibility, trip authorization, scheduling and all other documentation and forms.

- Preserve, and make available to EOHHS, such records and deliver them to EOHHS within five (5) business days of a written request, without additional expense to EOHHS. The Broker shall allow a reasonable number of persons, designated by EOHHS, to inspect, audit

or reproduce such records at the location where the Broker's records are normally maintained, without expense to EOHHS.

3.10.12 IMPLEMENTATION

The Broker must develop a plan to demonstrate its readiness to begin operations under a contract with EOHHS.

The Broker shall:

3.10.12.1 Be responsible for the preparation and execution of a Final Implementation Plan. The Final Implementation Plan shall be based upon the proposed implementation plan and shall outline, in detail, all the tasks necessary to begin full operations on January 1, 2019. The Final Implementation Plan shall specify expected dates of completion of all tasks, how the tasks will be accomplished, and the identity of the person(s) responsible for each task.

3.10.12.2 Coordinate a kick-off meeting with EOHHS no later than 30 days prior to the contract's period of performance as set forth in the statement of Intent to Award. The kick-off meeting shall consist, at a minimum, of the following:

(a) Reviewing the implementation project mission;

(b) Reviewing and revising the proposed implementation plan, as necessary;

(c) Determining the deliverable review process;

(d) Determining the format and protocol for project status meetings;

(e) Determining the format for project status reports;

(f) Defining lines of communication and reporting relationships; and

(g) Identifying and planning resolution of high-risk or problem areas.

3.10.12.3 Submit the Final Implementation Plan to EOHHS for review and approval within ten (10) business days of the kick-off meeting. Implementation activities shall not commence prior to EOHHS approval of the Final Implementation Plan.

3.10.12.4 Upon contract award, submit to EOHHS, for review and approval, a Broker Operations Manual detailing all procedures to be used in scheduling and delivery of transportation services. EOHHS shall complete a review within thirty (30) business days after the contract award. Any modifications required by EOHHS shall be incorporated into the Broker Operations Manual and resubmitted for review within fifteen (15) business days of receipt. The Broker shall not be allowed to begin operations without an approved Broker Operations Manual.

3.10.12.5 Submit a written report of progress to EOHHS every week during the Implementation phase. The progress report shall specify accomplishments during the report period in a task-by-task format, whether the implementation tasks are being performed on schedule and any administrative problems encountered. The report shall be due by the close of business each Friday.

3.10.12.6 Work with EOHHS to establish an approved secure file transfer to/from RI's Medicaid Management Information System (MMIS). All data transfers shall be processed according to

EOHHS file specifications. If at any time during the course of this contract, EOHHS implements a new MMIS, the Broker shall be expected to interface with the newly implemented MMIS. The MMIS will comply with the CMS Seven Conditions and Standards and MITA 3.0 requirements.
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf
https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html

3.10.12.7 Submit to EOHHS, sixty (60) calendar days prior to the commencement of services, the final plan, forms, inspection stickers and a list of trained inspectors who are authorized to inspect the vehicles on behalf of the Broker. Broker inspection requirement must be approved by EOHHS.

3.10.13. OPERATIONAL READINESS REVIEW

3.10.13.1 It is EOHHS' intent to have a fully-operational brokerage system contract effective January 1, 2019, and for each day of the resultant contract term thereafter. The Broker shall engage in good-faith negotiations to execute TP contracts before January 1, 2019. Furthermore, the Broker shall participate in transitional activities with the current Broker, if necessary, and shall participate in an Operational Readiness Review to be conducted by EOHHS thirty (30) days before the operations start date.

EOHHS shall conduct readiness reviews to ensure the Broker is prepared to perform the requirements of the agreement. EOHHS will identify to the Broker areas where EOHHS does not deem the Broker to be ready to meet its obligations under the tentative award. EOHHS will provide reasonable opportunity for the Broker to correct such areas to remedy all deficiencies prior to the contract effective start date. Funding shall also be withheld until the Broker passes the Operational Readiness Review. Once the Operational Readiness Review has been completed and approved by EOHHS, the Broker shall be allowed to begin taking reservations approximately ten (10) business days before transportation services are to begin.

If, for any reason, the Broker does not fully satisfy EOHHS that it is ready and able to perform its obligations under the tentative award prior to the contract start date, then EOHHS may chose not to enter into a contract.

3.10.13.2 In the event EOHHS determines that the Broker is not ready to provide services by January 1, 2019, EOHHS shall take such action as may be required to assure the seamless delivery of services. The Broker's failure to pass the Operational Readiness Review, to provide a fully-operational system on January 1st, 2019 or to maintain a fully-operational system thereafter will cause considerable harm to EOHHS and its recipients and shall result in liquidated damages**.** Such failure may also result in cancellation of the contract or other remedies as set forth in this RFP. The Broker shall be liable to EOHHS for damages if they are not fully operational. However, the Broker shall not be liable for such damages if the Broker is not fully operational because EOHHS has failed to meet its obligations under the contract and that failure was a direct cause of the delay.

3.10.13.3 The Broker shall demonstrate, during the Operational Readiness Review, readiness of the following systems, processes, and documentation:

(a) Call Center operations (this includes sufficient staff, telephone services and computer systems interaction);

(b) Simulated load test of all critical systems including telecommunications system capacity and reservation computer systems capacity;

(c) Simulated load test of all scheduled recurring trips from the previous Broker for dates of service on or after the stated Implementation Date;

(d) Capacity of Broker to maintain, receive and communicate all system files

(e) Capacity to produce required reports, including ad hoc reports;

(f) Standard TP contracts;

(g) Executed contracts with TPs;

(h) Evidence of operational TP Network to include mode of service requirements statewide;

(i) Recipient processes for obtaining services;

(j) Scheduling and carrier trip notification procedures;

(k) After-hours coverage arrangements;

(l) Business Continuity Plan;

(m) Denial process;

(n) Complaint process;

(o) Quality assurance process and procedures;

(p) Appeal process;

(q) Vehicle inspection reports;

(r) Compliance with technological requirements including AVL requirements

(s) Encounter data submission procedure;

(t) Reporting procedures (including templates) and calculations for reporting;

(u) Staffing in compliance with this RFP and the Broker's proposal;

(v) Clear and useable written policies and procedures;

(w) Trained Customer Service Representatives;

(x) The Broker's telephone system must be fully operational and staff training shall be completed for the Operational Readiness Review thirty (30) business days prior to the effective date of operations.

3.10.14 TURNOVER

3.10.14.1 The Broker shall develop, no later than ninety (90) calendar days after the beginning of the second year of the initial contract term, a EOHHS-approved Turnover Plan covering the possible turnover of the records and information maintained to either EOHHS or a successor Broker. EOHHS must ensure that program stakeholders do not experience any adverse impact from the transfer of the responsibility of providing brokerage services from the Broker to either EOHHS or a successor Broker. The Turnover Plan shall be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks outlined in the items below.

(a) The Broker shall provide EOHHS, as part of the Turnover Plan, copies of all relevant data and reference tables, documentation, or other pertinent information necessary to assume the operational activities successfully. This includes current inventories, correspondence, documentation of ongoing outstanding issues, and other operations support documentation.
(b) The Turnover Plan shall describe the Broker's approach and schedule for transfer of inventories and operational support information, as applicable.
(c) Supply the information in media and format specified by EOHHS and according to the schedule approved by EOHHS.

3.10.14.2 EOHHS is not limited or restricted in the ability to require additional information from the Broker or to modify the turnover schedule as necessary. At the expiration or termination of this contract, or if at any time EOHHS desires a transition of all or any part of the duties and obligations of the Broker to EOHHS or to another Broker, EOHHS shall notify the Broker of the need for transition. Such notice shall be provided at least ninety (90) calendar days prior to the date the contract will expire, or at the time EOHHS provides notice of termination to the Broker.

3.10.14.3 The transition process shall commence immediately upon notification and must, at no additional cost to EOHHS, continue past the date of contract termination or expiration if, due to the actions or inactions of the Broker, the transition process is not completed before that date.

3.10.14.4 Within ten (10) business days after receipt of the notice of the need for transition, EOHHS shall provide the Broker with written instructions, which shall include, but not be limited to, the following:

(a) The packaging, documentation, delivery location, and delivery date of all records, data, and review information to be transferred. The delivery period must not exceed thirty (30) calendar days from the date the instructions are issued by EOHHS.

(b) The date, time, and location of any transition meeting to be held among EOHHS, the Broker and any incoming Broker. The Broker must provide a minimum of two (2) individuals to attend the transition meeting and those individuals must be proficient in and knowledgeable about the materials to be transferred.

(c) Within five (5) business days after receipt of the materials from the Broker, EOHHS must submit to the Broker in writing any questions EOHHS has with regard to the materials transferred by the Broker. Within five (5) business days after receipt of the questions, the Broker must provide written answers to EOHHS.

(d) All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this Contract must become the sole property of EOHHS. Upon request, the Broker must promptly provide an acknowledgment or assignment in a tangible form satisfactory to EOHHS to evidence EOHHS' sole ownership of specifically identified intellectual property created or developed in the performance of the contract. This includes, but is not limited to, any call center telephone number(s) established for Medicaid.

3.10.14.5 Following turnover of operations, the Broker shall provide EOHHS with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. The outline and format of the Turnover Results report must be approved by EOHHS in advance. Turnover will not be considered complete until this document is approved by EOHHS.

3.10.14.6 The final administrative payment to the Broker will be withheld until ninety (90) calendar days following contract termination or until all data is updated on required systems and all records and information are received and verified by EOHHS or the subsequent vendor in the format required and the final Turnover Results report is completed and submitted to EOHHS.

3.10.14.7 The Broker must maintain all files for ten (10) years after the date of final payment under the contract and seven years after the resolution of all litigation, claims, financial management reviews or audits pertaining to the contract. The Broker agrees to repay any valid, undisputed audit exceptions taken by EOHHS.

3.10.15 LIQUIDATED DAMAGES

The Broker must deliver all contractual services to the standards called for in this RFP. The tasks outlined in Sections 3 and 4 shall be met fully, satisfactorily, and performed in their entirety.

In the event of any failure by the Broker to satisfy the specific requirements outlined below during the term of this contract, EOHHS may impose upon the Broker the associated liquidated damages.

(a) At EOHHS' option, the accuracy of performance results, performance level, and execution of key expectations may be measured by independent audit.

(b) Amounts due EOHHS pursuant to liquidated damages may be withheld from the Broker's administrative monthly payment amount or paid directly to EOHHS.

The Broker will work with EOHHS on a reporting structure to allow for measurement of any potential liquidated damage. Requirement thresholds in the table below indicate measurement of all three programs in aggregate.

3.10.15.1 Liquidated Damages Table

LIQUIDATED DAMAGES		
3.10	**OPERATIONAL REQUIREMENTS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed below for the following specific requirements listed in **3.10 Operational Requirements**: **3.10.1.1** Process Trip Requests-Liquidated damages in the amount of one hundred dollars ($100) per occurrence, for each occurrence where the Broker fails to schedule valid service requests. **3.10.1.2** Verify Recipient Eligibility-Liquidated damages in the amount of one hundred dollars ($100) per occurrence, for each occurrence where the Broker schedules an NEMT trip for a non-eligible recipient. **3.10.1.5** Process Retroactive Eligibility Claims-Liquidated damages in the amount of one hundred dollars ($100) per occurrence, for each occurrence where

LIQUIDATED DAMAGES		
		the Broker fails to reimburse contracted and non-contracted TPs for stretcher level, BLS, and ALS transportation services rendered to individuals that have eligibility approved retroactively to the time service was rendered. Reimbursement is limited to services rendered within ninety (90) days from the date of service. **3.10.1.6** Fulfill Trip Requests- Liquidated damages in the amount of one hundred dollars ($100) per occurrence, for each occurrence where the Broker fails to fulfill a verified trip request safely and on-time. **3.10.8.1** Report Accidents, Injuries, and Incidents - Liquidated damages in the amount of one thousand dollars ($1000) per occurrence, for each occurrence where the Broker fails to report to EOHHS an accident, injury or incident that has occurred in conjunction with a scheduled trip if a Recipient was present in the vehicle. Accidents, injuries, and incidents shall be reported to EOHHS as follows: Tier One Complaint/Incident: Notification within six (6) hours or sooner upon notification from the TP, facility, or recipient; Tier Two Complaint/Incident: Notification within forty-eight (48) hours or sooner upon notification from the TP, facility, or recipient. **3.10.1.12** Conduct Recipient Satisfaction Surveys - Liquidated damages in the amount of one thousand five hundred dollars ($1,500) per quarter, for each quarter the Broker fails to achieve an overall customer satisfaction rating of greater than or equal to ninety percent (90%) quarterly. **3.10.1.13** Maintain Broker Websites - Liquidated damages in the amount of five hundred dollars ($500) per calendar day, for each calendar day or any portion thereof where the Broker's websites are unavailable. Websites shall be available twenty-four (24) hours a day, seven (7) days a week, with the exception of EOHHS-approved downtime for maintenance.
3.10.2	**CALL CENTER REQUIREMENTS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.2 Call Center Requirements**: **3.10.10.1.2** Liquidated damages in the amount of five hundred dollars ($500) per month, for each month the Broker fails to answer eighty-percent (80%) of all calls within thirty (30) seconds. The thirty (30) seconds does not include the initial announcement. **3.10.10.1.2** Liquidated damages in the amount of five hundred dollars ($500) per month, for each month the average number of calls abandoned is greater than or equal to one percent (5%).

LIQUIDATED DAMAGES		
		3.10.10.1.2 Liquidated damages in the amount of five hundred dollars ($500) per month, for each month the average time on hold, for calls placed on hold after being initially answered, exceeds three (3) minutes. **3.10.10.1.6** For Quality Monitoring-Liquidated damages in the amount of five hundred dollars ($500) per month, for each month all reviewed calls fail to score ninety percent (90%) or higher
3.10.3	**TRANSPORTATION SERVICES AUTHORIZATION**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.3 Transportation Services Authorization**: **3.10.3.2.1** Recipient and Trip Eligibility Verification - Liquidated damages in the amount of one hundred dollars ($100) per occurrence for each occurrence where the Broker fails to process trip assignments in accordance with 4.5.3.2.1. **3.10.3.3** Process Denial of Service Determination - Liquidated damages in the amount of one hundred dollars ($100) per occurrence for each occurrence where the Broker fails to correctly deny a request for NEMT services. **3.10.3.4** Process Trip Assignments- Liquidated damages in the amount of one hundred dollars ($100) per occurrence for each occurrence where the Broker fails to process trip assignments in accordance with 4.5.3.4.
3.10.3.6	**TRANSPORTATION PERFORMANCE STANDARDS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.3.6 Transportation Performance Standards:** **3.10.3.6.1**. On Time Performance Measure – On Time Pick Up - Liquidated damages in the amount of five hundred dollars ($500) per business day for each business day the Broker fails to achieve a Recipient on time pick up percentage greater than or equal to ninety percent (90%). **3.10.3.6.2** On Time Performance Measure – On Time Drop Off - Liquidated damages in the amount of five hundred dollars ($500) per business day for each business day the Broker fails to achieve a Recipient drop off percentage greater than or equal to ninety percent (95%).
3.10.4.2	**TP CONTRACTS**	EOHHS shall be entitled to impose upon the Contracted Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.4.2 TP Contract:**

LIQUIDATED DAMAGES		
		3.10.4.2 TP Records-Liquidated damages in the amount of five hundred dollars ($500) per occurrence for each occurrence where the Broker fails to establish and maintain records and related information in its file for each of its contracted TPs as outlined in 3.10.4.2.
3.10.5	**DRIVER AND VEHICLE REQUIREMENTS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in Section **3.10.5.5 Driver and Vehicle Requirements:** **3.10.5.10** Drivers excluded from participation in any federal program by CMS or the RI state Medicaid program-Liquidated damages in the amount of five thousand dollars ($5,000) per occurrence for each occurrence where the Broker's contracted TP is utilizing a driver or other employee that has been terminated from the Medicaid program by EOHHS for fraud or abuse.
3.10.6	**PAYMENT TO TPS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.6, Payment to TPs:** **3.10.6.2** (d) Liquidated damages in the amount of five hundred dollars ($500) per month for every month the Broker fails to provide a monthly report to EOHHS summarizing the claims payment processing.
3.10.9	**QUALITY ASSURANCE**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.9 Quality Assurance** **3.10.9.3.1** Corrective action plans-Liquidated damages in the amount of five hundred dollars ($500) per business day for every business day the Broker fails to implement corrective action plans in accordance with time frames established by EOHHS and/or CMS.
3.10.10	**MANAGEMENT AND PERFORMANCE REPORTS**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.10 Management and Performance Reports:** **3.10.10.2** Liquidated damages in the amount of one thousand dollars ($1,000) per occurrence for every monthly encounter submission that fails to achieve a monthly acceptance rate equal to or greater than 97%. **3.10.10**. Liquidated damages in the amount of five hundred dollars ($500) per management report for every management report the Broker fails to provide by the reporting deadline.

LIQUIDATED DAMAGES		
3.10.12	**IMPLEMENTATION**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.12 Implementation:** **3.10.12.2** Liquidated damages in the amount of one thousand dollars ($1,000) per business day for every business day past the required thirty (30) days from the effective date of the contract where the Broker fails to coordinate a kick-off meeting with EOHHS. **3.10.12.3** Liquidated damages in the amount of one thousand dollars ($1,000) per business day for every business day past the required ten (10) business days of the kick-off meeting where the Broker fails to submit the Final Implementation Plan to EOHHS. **3.10.12.5** Liquidated damages in the amount of five hundred dollars ($500) per business day for every business day past the close of business Friday due date where the Broker fails to submit a weekly progress report. **3.10.12.1** Liquidated damages in the amount of one thousand dollars ($1,000) per business day for each business day during which the Broker is not in compliance with the approved Final Implementation Plan.
3.10.13	**OPERATIONAL READINESS REVIEW**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirements listed in **3.10.13 Operational Readiness Review:** **3.10.13.3** Liquidated damages in the amount of five hundred dollars ($500) per business day for every business day past the required thirty (30) days from the effective date of the contract where the Broker fails to comply with the readiness review.
3.10.14	**TURNOVER**	EOHHS shall be entitled to impose upon the Broker liquidated damages in the amounts listed for the following specific requirement listed in **3.10.14, Turnover:** **3.10.14.1** Liquidated damages in the amount of one hundred dollars ($100) per business day for every business day later than ninety (90) calendar days after the beginning of the second year of the initial contract term where the Broker fails to provide a Turnover Plan.

SECTION 4: PROPOSAL

A. Technical Proposal

Narrative and format: The proposal should address specifically each of the following elements:

1. **Staff Qualifications**
   - **a.** Describe how the Broker will maintain sufficient levels of supervisory and support staff with sufficient training and work experience to perform all contract requirements on an ongoing basis, including a general manager and key staff. EOHHS shall have the right to require reassignment or removal of any staff found unacceptable to EOHHS.
   - **b.** Describe how the Broker will be required to provide planned physical location of staff, requirements for start-up, implementation, and ongoing operations.
   - **c.** Propose a staffing plan/model showing personnel categories and staffing equivalents for major categories of staff assigned to each activity. Responses must identify the persons proposed for the key positions by name; including resumes and a short narrative description summarizing relevant experience of all proposed key personnel. Resumes should include relevant project experience, description of the person's role on the project, dates of participation, and three references with names, addresses, telephone numbers and e-mail addresses.
   - **d.** Provide an organization chart for all key personnel and provide an updated organization chart with contact information for all key personnel no longer than 10 days after hire.

2. **Capability, Capacity, and Qualifications of the Offeror**
   - **a.** Describe the Broker's Ability to Fulfill Recipient Requests, Trip Requests and Recovery
   - **b.** Describe ability/experience with Verifying Recipient Eligibility
   - **c.** Describe the Broker's ability to reimburse transportation providers
   - **d.** Describe how the Broker will Report Accidents, Injuries, and Incidents
   - **e.** Describe how the Broker will monitor performance and consumer satisfaction
   - **f.** Describer how the Broker will integrate Websites, Mobile Applications & Other Innovations

3. **Work Plan**
   - **a.** Describe how the Broker will develop policies and procedures for authorizing, scheduling, managing, and making payment for all transportation services.
   - **b.** Describe how the Broker will subcontract for the actual transportation services with transportation providers
   - **c.** Describe how the Broker will develop a successful transportation provider network.
   - **d.** Describe how the Broker will ensure all drivers and vehicles providing transportation services meet the minimum requirements listed in the Provider and Vehicle Requirements section of this RFP.
   - **e.** Describe how the Broker will provide ongoing education throughout the life of the contract by the Broker for medical providers, TPs, and recipients.
   - **f.** Describe how the Broker will develop transportation service marketing materials,
   - **g.** Describe the Broker's standard complaint process and approach to handling complaints, whether verbal or written, from recipients, TPs, healthcare providers and other facilities, EOHHS, other interested parties or the Broker itself. Include written procedures and processes that will be used by the Broker to receive and respond to all complaints about transportation services and the use of technology to aid in determining the validity of complaints.
   - **h.** Describe how the Broker will develop a plan to demonstrate its readiness to begin operations under a contract with EOHHS as outlined in section 4.5.12 Implementation of this RFP.

4. **Approach Proposed**
   - **a.** Describe the Broker's overall approach to providing a quality service delivery, including proposed plans for generating all of the required reports as well as development of any ad hoc reports required by EOHHS.

B. Cost Proposal

1. Bidder must acknowledge and attest to identified pricing structure or submit a cost proposal that does not exceed the maximum limit set in the pricing structure, if a Bidder does not propose an alternative strategy.
2. Attestations will be evaluated as a Pass/Fail
3. If an alternative strategy is proposed, this will be evaluated and should include rates for the 3.5 years as define in Appendix X.

C. ISBE Proposal

See APPENDIX I for information and the MBE, WBE, and/or Disability Business Enterprise Participation Plan form(s). Bidders are required to complete, sign and submit these forms with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

SECTION 5: EVALUATION AND SELECTION

Proposals shall be reviewed by a technical evaluation committee ("TEC") comprised of staff from State agencies. The TEC first shall consider technical proposals.

Technical proposals must receive a minimum of 60 (85.7%) out of a maximum of 70 points to advance to the cost evaluation phase. Any technical proposals scoring less than 60 points shall not have the accompanying cost or ISBE participation proposals opened and evaluated. The proposal will be dropped from further consideration.

Technical proposals scoring 60 points or higher will have the cost proposals evaluated and assigned up to a maximum of 30 points in cost category bringing the total potential evaluation score to 100 points. After total possible evaluation points are determined ISBE proposals shall be evaluated and assigned up to 6 bonus points for ISBE participation.

The Division of Purchases reserves the right to select the vendor(s) or firm(s) ("vendor") that it deems to be most qualified to provide the goods and/or services as specified herein; and, conversely, reserves the right to cancel the solicitation in its entirety in its sole discretion.

Proposals shall be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Staff Qualifications	5 Points
Capability, Capacity, and Qualifications of the Offeror	30 Points
Work Plan	15 Points
Approach Proposed	20 Points
Total Possible Technical Points	**70 Points**
Cost proposal*	30 Points
Total Possible Evaluation Points	**100 Points**
ISBE Participation**	6 Bonus Points
Total Possible Points	**106 Points**

*Cost Proposal Evaluation:

The vendor with the lowest cost proposal shall receive one hundred percent (100%) of the available points for cost. All other vendors shall be awarded cost points based upon the following formula:

(lowest cost proposal / vendor's cost proposal) x available points

For example: If the vendor with the lowest cost proposal (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly costs and service fees and the total points available are thirty (30), Vendor B's cost points are calculated as follows:

$65,000 / $100,000 x 30= 19.5

**ISBE Participation Evaluation:

a. Calculation of ISBE Participation Rate

1. ISBE Participation Rate for Non-ISBE Vendors. The ISBE participation rate for non-ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of non-ISBE vendor's total contract price that will be subcontracted to ISBEs by the non-ISBE vendor's total contract price. For example if the non-ISBE's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs, the non-ISBE's ISBE participation rate would be 12%.

2. ISBE Participation Rate for ISBE Vendors. The ISBE participation rate for ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of the ISBE vendor's total contract price that will be subcontracted to ISBEs and the amount that will be self-performed by the ISBE vendor by the ISBE vendor's total contract price. For example if the ISBE vendor's total contract price is $100,000.00 and

it subcontracts a total of $12,000.00 to ISBEs and will perform a total of $8,000.00 of the work itself , the ISBE vendor's ISBE participation rate would be 20%.

b. Points for ISBE Participation Rate:

The vendor with the highest ISBE participation rate shall receive the maximum ISBE participation points. All other vendors shall receive ISBE participation points by applying the following formula:

(Vendor's ISBE participation rate ÷ Highest ISBE participation rate

X Maximum ISBE participation points)

For example, assuming the weight given by the RFP to ISBE participation is 6 points, if Vendor A has the highest ISBE participation rate at 20% and Vendor B's ISBE participation rate is 12%, Vendor A will receive the maximum 6 points and Vendor B will receive (12% ÷ 20%) x 6 which equals 3.6 points.

General Evaluation:

Points shall be assigned based on the vendor's clear demonstration of the ability to provide the requested goods and/or services. Vendors may be required to submit additional written information or be asked to make an oral presentation before the TEC to clarify statements made in the proposal.

SECTION 6. QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference **RFP # 7591562** on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 7. PROPOSAL CONTENTS

A. Proposals shall include the following:

1. One completed and signed RIVIP Bidder Certification Cover Form (included in the original copy only) downloaded from the Division of Purchases website at www.purchasing.ri.gov. *Do not include any copies in the Technical or Cost proposals.*

2. One completed and signed Rhode Island W-9 (included in the original copy only) downloaded from the Division of Purchases website at http://www.purchasing.ri.gov/rivip/publicdocuments/fw9.pdf**.** *Do not include any copies in the Technical or Cost proposals.*

3. Two (2) completed original and copy versions, signed and sealed APPENDIX I. MBE, WBE, and/or Disability Business Enterprise Participation Plan. Please complete separate

forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation. *Do not include any copies in the Technical or Cost proposals.*

4. Technical Proposal - describing the qualifications and background of the applicant and experience with and for similar projects, and all information described earlier in this solicitation. The technical proposal is limited to fifty (50) pages (this excludes any appendices and as appropriate, resumes of key staff that will provide services covered by this request).
    a. One (1) Electronic copy on a CD-R, marked "Technical Proposal - Original".
    b. One (1) printed paper copy, marked "Technical Proposal -Original" and signed.
    c. Six (6) printed paper copies

5. Cost Proposal - A separate, signed and sealed cost proposal reflecting the hourly rate, or other fee structure, proposed to complete all of the requirements of this project.
    a. One (1) Electronic copy on a CD-R, marked "Cost Proposal -Original".
    b. One (1) printed paper copy, marked "Cost Proposal -Original" and signed.
    c. Six (6) printed paper copies

B. Formatting of proposal response contents should consist of the following:

A. Formatting of CD-Rs – Separate CD-Rs are required for the technical proposal and cost proposal. All CD-Rs submitted must be labeled with:
    a. Vendor's name
    b. RFP #
    c. RFP Title
    d. Proposal type (e.g., technical proposal or cost proposal)
    e. If file sizes require more than one CD-R, multiple CD-Rs are acceptable. Each CD-R must include the above labeling and additional labeling of how many CD-Rs should be accounted for (e.g., 3 CD-Rs are submitted for a technical proposal and each CD-R should have additional label of '1 of 3' on first CD-R, '2 of 3' on second CD-R, '3 of 3' on third CD-R).

Vendors are responsible for testing their CD-Rs before submission as the Division of Purchase's inability to open or read a CD-R may be grounds for rejection of a Vendor's proposal. All files should be readable and readily accessible on the CD-Rs submitted with no instructions to download files from any external resource(s). If a file is partial, corrupt or unreadable, the Division of Purchases may consider it "non-responsive". USB Drives or any other electronic media shall not be accepted. Please note that CD-Rs submitted, shall not be returned.

B. Formatting of written documents and printed copies:
- For clarity, the technical proposal shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12 point Calibri or 12 point Times New Roman.
- All pages on the technical proposal are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Vendor's name should appear on every page, including

attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to.

- The cost proposal shall be typed using the formatting provided on the provided template.
- Printed copies are to be only bound with removable binder clips.

SECTION 8. PROPOSAL SUBMISSION

Interested vendors must submit proposals to provide the goods and/or services covered by this RFP on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases, shall not be accepted.

Proposals should be mailed or hand-delivered in a sealed envelope marked "**RFP# 7591562 Rhode Island Transportation Brokerage Services**" to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time shall not be accepted. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time shall be determined to be late and shall not be accepted. Proposals faxed, or emailed, to the Division of Purchases shall not be accepted. The official time clock is in the reception area of the Division of Purchases.

SECTION 9. CONCLUDING STATEMENTS

Notwithstanding the above, the Division of Purchases reserves the right to award on the basis of cost alone, to accept or reject any or all proposals, and to award in the State's best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

If a Vendor is selected for an award, no work is to commence until a purchase order is issued by the Division of Purchases.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded for this RFP. The State's General Conditions of Purchases can be found at the following URL: https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf.

APPENDIX I. PROPOSER ISBE RESPONSIBILITIES AND MBE, WBE, AND/OR DISABILITY BUSINESS ENTERPRISE PARTICIPATION FORM

4 Proposer's ISBE Responsibilities (from 150-RICR-90-10-1.7.E)

1. Proposal of ISBE Participation Rate. Unless otherwise indicated in the RFP, a Proposer must submit its proposed ISBE Participation Rate in a sealed envelope or via sealed electronic submission at the time it submits its proposed total contract price. The Proposer shall be responsible for completing and submitting all standard forms adopted pursuant to 105-RICR-90-10-1.9 and submitting all substantiating documentation as reasonably requested by either the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to the names and contact information of all proposed subcontractors and the dollar amounts that correspond with each proposed subcontract.

2. Failure to Submit ISBE Participation Rate. Any Proposer that fails to submit a proposed ISBE Participation Rate or any requested substantiating documentation in a timely manner shall receive zero (0) ISBE participation points.

3. Execution of Proposed ISBE Participation Rate. Proposers shall be evaluated and scored based on the amounts and rates submitted in their proposals. If awarded the contract, Proposers shall be required to achieve their proposed ISBE Participation Rates. During the life of the contract, the Proposer shall be responsible for submitting all substantiating documentation as reasonably requested by the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to copies of purchase orders, subcontracts, and cancelled checks.

4. Change Orders. If during the life of the contract, a change order is issued by the Division, the Proposer shall notify the ODEO of the change as soon as reasonably possible. Proposers are required to achieve their proposed ISBE Participation Rates on any change order amounts.
5. Notice of Change to Proposed ISBE Participation Rate. If during the life of the contract, the Proposer becomes aware that it will be unable to achieve its proposed ISBE Participation Rate, it must notify the Division and ODEO as soon as reasonably possible. The Division, in consultation with ODEO and Governor's Commission on Disabilities, and the Proposer may agree to a modified ISBE Participation Rate provided that the change in circumstances was beyond the control of the Proposer or the direct result of an unanticipated reduction in the overall total project cost.

5 MBE, WBE, AND/OR Disability Business Enterprise Participation Plan Form:

Attached is the MBE, WBE, and/or Disability Business Enterprise Participation Plan form. Bidders are required to complete, sign and submit with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF ADMINISTRATION
ONE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908

MBE, WBE, and/or DISABILITY BUSINESS ENTERPRISE PARTICIPATION PLAN

Bidder's Name:
Bidder's Address:
Point of Contact:
Telephone:
Email:
Solicitation No.:
Project Name:

This form is intended to capture commitments between the prime contractor/vendor and MBE/WBE and/or Disability Business Enterprise subcontractors and suppliers, including a description of the work to be performed and the percentage of the work as submitted to the prime contractor/vendor. Please note that all MBE/WBE subcontractors/suppliers must be certified by the Office of Diversity, Equity and Opportunity MBE Compliance Office and all Disability Business Enterprises must be certified by the Governor's Commission on Disabilities at time of bid, and that MBE/WBE and Disability Business Enterprise subcontractors must self-perform 100% of the work or subcontract to another RI certified MBE in order to receive participation credit. Vendors may count 60% of expenditures for materials and supplies obtained from an MBE certified as a regular dealer/supplier, and 100% of such expenditures obtained from an MBE certified as a manufacturer. This form must be completed in its entirety and submitted at time of bid. **Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.**

Name of Subcontractor/Supplier:					
Type of RI Certification:	□ MBE □ WBE □ Disability Business Enterprise				
Address:					
Point of Contact:					
Telephone:					
Email:					
Detailed Description of Work To Be Performed by Subcontractor or Materials to be Supplied by Supplier:					
Total Contract Value ($):		Subcontract Value ($):		ISBE Participation Rate (%):	
Anticipated Date of Performance:					

I certify under penalty of perjury that the forgoing statements are true and correct.

Prime Contractor/Vendor Signature	**Title**	**Date**
Subcontractor/Supplier Signature	**Title**	**Date**

M/W/Disability Business Enterprise Utilization Plan - RFPs - Rev. 5/24/2017

APPENDIX II. – PERFORMANCE BOND

The successful bidder shall provide upon selection and execution of a mutually satisfactory contract and prior to the issuance of a purchase order, a performance bond for $1 million dollars for the work to be performed under the contract and for the benefit of the State of Rhode Island and its successor. All surety companies must be listed with the Department of Treasury, Fiscal Services, Circular 570, (Latest Revision published by the Federal Register). The Purchasing Agent reserves the right to consider and accept alternative forms security.

The Broker shall supply security no later than June 1, 2017. The Broker shall supply security in the form of cash, cash equivalent or an unconditional irrevocable standby letter of credit, on deposit in or issued by, respectively, a federal or state chartered bank with offices physically located in the State of Rhode Island in the amount of two million dollars US ($2,000,000.00) whereby funds are (1) pledged to the benefit of the State; (2) are not under the control of the Broker; and (3) are payable to the RI Executive Office of Health and Human Services upon written demand to the holder.

This security is for the faithful performance of this contract between the State and Broker and will further protect, indemnify and hold harmless the State from all costs and damages by reason of the Broker's default, breach or failure to satisfactorily perform the obligations outlined in this RFP, the Broker's response thereto, and any amendments, modifications or change orders.

Not sooner than twelve (12) months following the commencement of performance, the Broker may seek a reduction in the amount of the security and consideration for such a request will depend on Broker's performance up to the time of the request and the time remaining under the contract. Further, any revenue or other yield generated by the security shall be owned by the Broker and may be withdrawn periodically so long as then applicable minimum security amount is maintained.

In the event of any condition of breach or other circumstance attributable to the Broker, the RI Executive Office of Health and Human Services shall have the right to draw against the security such sums as are necessary to make the State whole, including, but not limited to, the costs incurred to secure and compensate for substituted services of another entity made necessary by the breach. Nothing herein shall be construed to mean that the security provided for herein is exclusive or constitutes any limitation or restriction on any remedies to which the State may be entitled.

APPENDIX III. LIST OF BORDER COMMUNITIES

- **Border communities include cities and towns that border Rhode Island and are considered, for the purpose of the Rhode Island Medical Assistance Program and Rhode Island Elderly Transportation Program, as in-state communities. Out-of-state restrictions and prior-authorization requirements are not imposed in the following communities:**

Connecticut	Massachusetts
Danielson	Attleboro
Groton	Bellingham
Moosup	Blackstone
Mystic	Dartmouth
New London	Fall River
North Stonington	Foxboro
Pawcatuck	Milford
Putnam	New Bedford
Stonington	North Attleboro
Thompson	North Dartmouth
Waterford	Rehoboth
	Seekonk
	Somerset
	South Attleboro
	Swansea
	Taunton
	Uxbridge
	Webster
	Westport
	Whitinsville

APPENDIX IV. SYSTEMS REQUIREMENTS

EOHHS requires the use of technology to automate processes, maximize system efficiency and allow for the use of consistent and accurate data across programs.

The computer system must be adequate to support all operational and reporting functions under this RFP. Broker's computer system must comply with the American Disabilities Act (ADA) development standards for user screens.

1. Computer Systems and Data

The Broker shall possess and maintain the following computer system and data standards:

1.1 Maintain sufficient computer hardware, software, and Internet capability to support service authorization, trip scheduling/dispatch, provider reimbursement, complaint monitoring, as well as to meet all data capture, data storage and reporting requirements established under this RFP.

1.2 The Broker shall possess and maintain a claims processing system that assures compliance with all Technical Requirements to assure only claims for appropriate services provided by authorized providers for eligible members are paid. This system must have appropriate edits and audits to monitor and detect duplicate services, services limitations and overage and guard against fraudulent billing.

1.3 The Broker shall possess and maintain a claims processing and payment system that accepts and processes HIPAA 837 electronic claims, CMS 1500 claim forms and proprietary claim forms.

1.4 The Broker must have an ability to work with the State's MMIS vendor and systems as it relates to files/claims information exchanges

1.5 Obtain maintenance contracts with equipment and software suppliers for the duration of the contract. Maintenance contracts must be sufficient to ensure the efficient operation of the system in compliance with this RFP. Software maintenance contracts must include upgrades, enhancements, and bug fixes. The Broker must maintain adequate licensing agreements for all software used under this contract. Hardware maintenance contracts must include service and replacement or repair for all hardware used under this contract.

1.6 All hardware, software, and firmware products, individually and in combination, shall be compatible with and able to exchange data with EOHHS and EOHHS's Fiscal Agent, including member enrollment data, provider data, encounter data, and other information and/or reports.

1.7 Perform all file and system maintenance functions to the system. The Broker shall be responsible for providing, at no additional cost to EOHHS, data processing expertise, data processing equipment, programmers and operators, and other related technical support associated with the operation and maintenance of the computer system(s) used under this contract.

2. Security

The system must meet all Federal and State privacy and security requirements including but not limited to:

2.1 Provide user access through role-based security. The application must provide tests for authentication (generally a login process) and role based security, authorization (determines whether a user has the required role to access a resource).

2.2 Provide data protection and recovery plans.

2.3 Ensure unauthorized users do not gain access to records.

2.4 Meet or exceed all applicable Federal and State standards for security and privacy, including but not limited to, HIPAA.

2.5 Provide 24/7 system maintenance and support service for system failures that would prevent a member from getting services.

2.6 Schedule system maintenance hours to occur between midnight and 4:00a.m. Eastern Standard Time.

2.7 The database shall be backed up on a regular schedule, at least once each day. Back up data must be stored at an off-site location approved by EOHHS.

2.8 The system must be configurable to allow multiple access rights, and security levels based on the user account.

2.9 The system must allow for authentication through username and password.

2.10 The systems may allow for authentication through a shared core service (that also provides authentication for other applications).

2.11 The system must provide secure data transmission (e.g., SSL encryption for communication over the Internet). This includes data transmitted via the internet, email, or other electronic transmission.

2.12 The system shall maintain audit records detailing access to the system and modification of records. Audit records should include (at a minimum) date, time, user, record ID, and action performed.

2.13 Employ user-configurable online and batch audit trail functionality that provides electronic capture and storage of audit trail information related to all data inputs and uploads, changes and modifications, inquiries, authorizations, access requests, archive and retrieval processes, and log files, and make them available for inquiry.

3. Software

The reservation/scheduling transportation software used by the Broker must have the following capabilities.

3.1 Maintaining or interfacing with a database of transportation providers with which the Broker has service agreements, including reimbursement and other information needed to determine trip assignments.

3.2 Automatic address validations, distance calculations and trip pricing, if applicable.

3.3 Standing order subscription trip and random trip reservation capability.

3.4 Ability to determine if public transportation or other fixed route services are available to the members.

3.5 Ability to determine if federally funded transportation is available to the members.

3.6 Ability to capture all data elements required by the electronic member worksheet or call center

script.

3.7 Must be currently commercially available, or if proprietary or a modified commercial product, currently operational in at least one site and available for demonstration to EOHHS

4. Database

The Broker shall establish and maintain a member and provider database.

4.1 Members

The member database shall be capable of maintaining such information as basic demographic information, NEMT/ETP/TANF eligibility and special transportation needs. The member database shall include, but is not limited to:

4.1.1 Member name.

4.1.2 Member ID.

4.1.3 Member address.

4.1.4 Member date of birth.

.

4.1.5 Contact information (e.g., telephone, email).

4.1.6 Program eligibility information.

4.1.7 Third party liability information.

4.1.8 Special needs/requirements (i.e. medical condition, language, attendant required).

4.1.9 Required or preferred mode of transportation (e.g. wheelchair).

4.1.10 Challenging behavior.

4.1.11 Complaint history.

4.1.12 "No-show" history.

4.2 Providers

The Broker shall establish and maintain an electronic provider database sufficient to meet the needs of the transportation program. EOHHS will provide the Broker with a file of current Medicaid certified transportation providers (taxi, wheelchair/ ambulatory vans, paratransit) in a format and specifications of the file to be determined.

The Broker will be responsible for loading this provider data into the system and utilizing the data when scheduling and dispatching transportation. In addition, the Broker is responsible for obtaining and maintaining data for all transportation providers (e.g. public motor vehicle carriers, taxis, public transportation). The provider database shall include, but is not limited to the following:

4.2.1 Provider ID - The Broker will be required to maintain the provider ID and NPI for identification purposes. In addition, the Broker must assign a unique provider ID for non-Medicaid certified providers public transit, taxis and public

motor vehicle carriers. The format of the ID must be such as to not cause duplicates of the Medicaid assigned NPI or ID assigned by the Broker. Measures must be put in place to ensure no duplicate provider are assigned or reused.

4.2.2 Provider demographic information (i.e., name, address, phone);

4.2.3 Effective and end dates of contract period and/or Medicaid certification dates;

4.2.4 Vehicle information;

4.2.5 Driver information;

4.2.6 AVL information;

4.2.7 Other information that may be necessary to support transportation operations and reporting such as geographical coverage area, types of vehicles, and number of trips that can be accommodated per day.

4.3 Encounter Data

The Broker shall submit encounter data to EOHHS or its designee for all NEMT service provided on behalf of a member. The encounter data must be created from paid claims data and other data created or maintained by the Broker on services, providers and members.

The Broker shall establish quality control procedures and edits to allow for the detection and correction of errors prior to submission of encounter data to EOHHS

4.3.1 Submissions and Format

The Broker shall electronically transmit encounter data to EOHHS and/or Fiscal Agent. The data elements on the encounter record will be based on the Centers for Medicare and Medicaid Services (CMS) 1500 claim form data elements.
Other data elements may be specified by EOHHS such as information pertaining to the trip (trip log data) and network provider information, including reimbursement amounts.

The encounter data shall be provided monthly to EOHHS within ten (10) business days after the close of the month using SFTP – Secure File Transfer Protocol and in a format specified by EOHHS. The content and layout of these files are subject to change to accommodate the needs of EOHHS. The Broker shall be required to update subsequent versions of the encounter data format, at no additional cost.

EOHHS will process the Broker's encounter file against established validation criteria and create an error file of those records that fail the validation process. The Broker shall review the error file to determine the need for changes and resubmission. In the event the data submission contains erroneous data as determined by EOHHS, the Broker has thirty (30) days to correct the errors and resubmit to EOHHS.

The Broker will be required to test encounter data submission until EOHHS is satisfied that the Broker is capable of submitting valid, accurate, and timely encounter data according to the requirements of this RFP.

The Broker must use State-defined standardized naming conventions for encounter data submissions. Files must be compressed using a standard zip program (e.g., WinZip,).

The Broker must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number (RIN) for each encounter.

5. Website

The Broker shall provide and maintain an Internet website for Rhode Island's Medicaid NEMT and ETP recipients and the network transportation providers to access information pertaining to Rhode Island's transportation services. Broker will continually update this website to add increased functionality.

Over time, EOHHS would like the Broker to move towards a statewide web-based automated transportation reservation system. The EOHHS will retain ownership of the web URL address at all times. The Broker will describe how this will be accomplished and over what time period.

The website design and content must be presented in a user friendly, intuitive manner and provide for the information and content to be viewed and/or downloadable. The Broker shall update the website as needed to reflect changes and revisions in the transportation services program. Updates to the website must be applied within three (3) business days of receipt of EOHHS-approved content changes. Any non-availability of the website must be addressed within one hour of discovery.

The Broker shall submit any website content specific to Rhode Island's transportation programs to EOHHS for review and acceptance prior to posting the information on the website.

5.1 NEMT Provider Content

The website shall provide, at a minimum, the following information about the Broker/transportation manager:

5.1.1 Central business office address, phone, and fax number;

5.1.2 Directions to the Broker's central business office and office hours;

5.1.3 Information for Transportation Providers;

5.1.4 Frequently asked questions (FAQ) for NEMT and ETP recipients and service providers;

5.1.5 NEMT policies, procedures & manuals;

5.1.6 Transportation provider meeting/training dates, time, and locations;

5.1.7 Sample reporting requirements, instructions, and templates as applicable;

5.1.8 Transportation Provider education and training plan updates.

5.2 Member Content

The website shall provide, at a minimum, the following information for members:

5.2.1 Call Center contact information, including information for after-hours assistance;

5.2.2 Description of transportation services available and how to access them;

5.2.3 How to file a complaint or grievance;

5.2.4 Member responsibilities;

5.2.5 Member conduct;

5.2.6 Links to other web sites as determined by EOHHS;

5.2.7 Frequently asked questions (FAQs), including definitions.

6. Disaster Recovery

The Broker must develop and maintain a disaster recovery plan designed to minimize any disruption to transportation services. It is the sole responsibility of the Broker to maintain adequate backup to ensure continued scheduling and transportation capability.

6.1 Minimum Components

At a minimum, the disaster recovery plan must include the following components:

6.1.1 Measures taken to minimize the threat of a disaster at the Broker's central business office and other facilities, including physical security and fire detection and prevention.

6.1.2 Provisions for accepting member telephone calls and scheduling transportation in the event of a disaster at the Broker's central business office or the failure of the Broker's telephone system.

6.1.3 Procedures utilized to minimize the loss of required records in the event of fire, flood, or other disaster.

6.1.4 Off-site storage.

The Proposal must include an initial Disaster Recovery Plan. A final disaster recovery plan must be submitted to EOHHS for review and approval at least thirty (30) calendar days prior to the start of operations. Modifications required by EOHHS must be incorporated by the Broker within ten (10) calendar days of notification. In no case will a Broker be allowed to begin operations without an approved disaster recovery plan.

The Broker must update on an annual basis and submit a complete revised plan within fifteen (15) working days following the end of the contract year. In addition, the Broker must complete interim updates within ten (10) working days of change in procedures.

7. Archiving

All records shall be maintained and available for review by authorized federal and state personnel during the entire term of the contract in compliance with State and Federal record retention requirements which are ten (10) years for medical records, source records and financial records and seven (7) years for litigation, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept for a period of 10 years or until all issues are finally resolved, whichever is later.

APPENDIX V. COVERED SERVICES FOR MEDICAID NEMT

Rhode Island Medicaid Covered & Non-Covered Services	Covered	Not covered
AA or self-help groups		X
Abortion (elective)		X
Abortion (medically necessary)	X	
Acupuncture	X	
Adult Day Healthcare	X	
Alcohol abuse evaluation to enter a treatment program	X	
Alcohol rehabilitation program	X	
Allergy	X	
Aquatic therapy (one on one with physical therapist at PT office)	X	
Audiology and hearing aids	X	
Botox Injections (non-cosmetic) - administered by a physician	X	
Cardiac Rehabilitation	X	
Case Management *(transporting a member to his/her case manager)*	X	
Chemotherapy/Radiation	X	
Chiropractor services (non-Medicare)	X	
Clinical psychologist services	X	
Contact lenses, eye exams, eye glass fittings	X	
Counseling Provided by a Social Worker (independent, not associated with a clinic)	X	
Cosmetic surgery (elective)		X
Dental services	X	
Dermatology	X	
Diabetic education and transport to pick up supplies	X	
Diabetic Nutritional Counseling	X	
Diagnosis, screening, preventive and rehabilitative services	X	
Dialysis	X	
Durable medical equipment (fittings, supply pick-up)	X	
Durable medical equipment: Wheelchair Repair	x	
Emergency Room Trips When Urgent Care is Needed	X	
Emergency Room Discharge (see also Hospital Discharge below)		X
Emergency Room Trips To Get A Drug Prescription		X
Early Periodic Screening, Diagnosis & Treatment for members under age 21	X	
Examination for Social Security Eligibility Determination		X
Exercise Gyms (even when ordered by a physician)		X
Experimental procedures/drugs		X
Fair Hearing: transport to		X
Family planning services	X	
Federally qualified health center services	X	
Follow-up Appointments	X	
Follow-up to surgery (including foot care, wound dressing)	X	
Free-standing clinic services	X	
Gender Reassignment Surgery	X	
Group therapy (with RI-licensed therapist)	X	

Hearing: Family Court, Drug Court, etc.		X
Home healthcare (HHC): transporting HHC workers to a member's home		X
Horseback riding therapy	X	
Hospital admission	X	
Hospital discharge (see also Emergency Room Discharge above)		X
Hospital inpatient transportation *(hospital-to-hospital DRG)*		X
Hospice *(to hospice usually covered, otherwise not covered)*	X	
Inpatient and outpatient hospital services	X	
Inpatient psychiatric facility services for individuals under age 21 or over age 65	X	
To or from medical only, not day program or employment	X	
Laboratory and X-ray services	X	
Lamaze/birthing technique classes	X	
Mammogram	X	
Massage Therapy	X	
Medical and surgical dental services	X	
Midwife services	X	
Music therapy	X	
Nurse midwife	X	
Nurse practitioner	X	
Nursing facility services	X	
Nursing home to nursing home (medically necessary)	X	
Nutritional counseling	X	
OB/GYN Services	X	
Occupational therapy	X	
Ophthalmology	X	
Optometrist services and eyeglasses	X	
Orthodontia (under age 18)	X	
Orthopedics	X	
Outpatient/ambulatory surgery	X	
Paternity testing		X
Pharmacy: as part of transport to and from the doctor	X	
Pharmacy: standalone trip to and from the pharmacy	X	
Physical, speech and occupational therapies	X	
Physician services	X	
Pick up X-Rays/test results (no examination)		X
Podiatry (Qualified Medicare Enrollee or under age 18)	X	
Prosthetic devices and orthotic appliances	X	
Psychiatrist/Psychologist	X	
Psychology	X	
Research Programs		X
Rural health clinic services	X	
Club House / a treatment modality for psych patients	X	
Medicaid funded support groups	X	
Service animal training course		X
Sheltered workshop		X

Smoking cessation	X	
Speech therapy	X	
SSI Determination Hearing (see Examination for SSI Determination above)		X
Summer camp programs		X
Transplant Services	X	
Transport belongings from hospital to member at another location	X	
Transportation to the Emergency Room via 911 Ambulance		X
Transportation to the Grocery Store: standalone transport to and from		X
Transportation to the Grocery store after trip to and from doctor "to pick up a few things"		X
Visitation - parent visiting child who is hospitalized	X	
Treatment at Veteran's Affairs (VA) Hospital/Clinic		X
WIC Appointments		X
Workman's Compensation: transport to a hearing		X
X-Ray, MRI, EKG, EEG, etc.	X	

Key Personnel Table	Name	Years of Experience	% FTE Committed to this Role	Minimum Qualifications
General Manager				8 Years of like experience
Chief Information Officer				5 Years of like experience
Call Center Operations Manager				5 Years of like experience
Utilization Review Manager				5 Years of like experience
Quality Assurance Manager				5 Years of like experience
Transportation Provider Relations manager				5 Years of like experience
Complaints Manager				2 Years of like experience
Education and Training Manager				2 Years of like experience

APPENDIX VII. BROKER-TP CONTRACT REQUIREMENTS

The Broker shall provide transportation services through written subcontracts, which include at a minimum, the following terms and conditions that:

1. State clearly the functions to be subcontracted by the Broker, including services and activities covered under the contract.

2. Contain language that transportation providers shall have the following terms and conditions regarding the gathering and use of recipient information:

a. That only the minimal information necessary to provide services shall be requested of EOHHS's Broker.

b. That any recipient information gained shall be protected from unauthorized disclosure, in order to assure confidentiality of recipient information and medical records.

3. Identify the parties to the contract (e.g., name, address, type of organization) and identify their legal basis to do business in the State of Rhode Island.

4. Contains language that requires transportation providers to have procedures in place for the prevention, detection, and reporting of suspected FWA.

5. Describe the payment method, including applicable rates.

6. Require that the Broker remit amounts due to transportation providers no later than ten (10) calendar days after receipt of EOHHS's monthly payment for transportation services.

8. Contain a quality control clause.

9. Include requirements that each transportation provider maintains sufficient liability insurance to meet the requirements of RI State law and the Terms and Conditions of this contract regarding insurance coverage.

10. Require transportation provider agreement to comply with employer liability, worker's compensation, unemployment insurance, social security, and any other state and local taxes applicable to the transportation providers.

11. Provide for EOHHS's access to information and records for six (6) years following the expiration or termination of such subcontract, sufficient to document services provided under this contract including billing and accounting information.

12. Prohibit transportation providers from offering or making any payment or other form of remuneration, including any kickback, rebate, cash, gifts, or service in kind to the Broker in order to influence referrals or contracting for transportation See 42 CFR Section 170.

13. Require the transportation provider to return, within thirty days of Broker's or discovery, any and all payments for trips delivered by an unauthorized driver and/or vehicle.

14. Require the transportation provider to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activities to be performed under this Contract.

15. Require the transportation providers to comply with Quality Assurance Activities.

16. EOHHS reserves the right to direct the Broker to terminate any service agreement with a TP when EOHHS determines this to be in the best interest of the State.

APPENDIX VIII. SERVICE COMPLAINTS AND APPEALS

Broker's policies and procedures for processing grievances must permit a provider, acting on behalf of the member and with the member's written consent, to file an appeal of an action within 30 days from the date on the Broker's notice of action. An action means: (1) whether or not a service is a Covered Service; (2) the denial or limited authorization of a requested service, including the mode or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, as defined Section 3.1 of the RFP or (6) the failure of the Broker to act within the timeframes in Section 3.1 of this RFP.

A Notice of Action must be in writing and must explain:

- The action the Broker or its agents, has taken or intends to take
- The reasons for the action
- The Recipient's or provider's right to file an appeal with the Broker
- The Broker's right to a Fair Hearing
- The procedures for exercising the rights in this section
- The circumstances under which expedited appeal resolution is available and how to request it
- The Recipient's rights to have covered benefits continue pending resolution of the appeal and the final decision of EOHHS.
- How to request that benefits be continued and the circumstances under which the Recipient may be required to pay the costs of these services

The Broker must mail the notice of action to the Recipient within the timeframes specified in 42 CFR 438.404. Broker agrees to notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

In handling grievances and appeals the Broker must:

- Give members any reasonable assistance in completing forms and taking procedural steps, including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Acknowledge each grievance and appeal
- Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making and who, if deciding on any of the following, are healthcare professionals who have appropriate clinical expertise, as determined by the State, in treating the Recipient's condition or disease: (a) an appeal of a denial that is based on lack of medical necessity, (b) a grievance regarding denial of expedited resolution of an appeal; or (c) a grievance or appeal that involves clinical issues

Member Formal Appeals

To file an appeal, the process must:

a) Provide that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date) and must be confirmed in writing, unless the recipient or the provider requests expedited resolution;
b) Provide the recipient a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
c) Provide the recipient and his or her representative opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeals process; under certain circumstances certain categories of medical

records and other documents may not be available to the member based on the type of record including but not limited to mental health records; and

d) Include, as parties to the appeal, the recipient and his or her representative, or the legal representative of a deceased recipient's estate.

The Broker must provide written notice of the disposition of all appeals within thirty (30) days from the time the Broker receives the appeal. For notice of an expedited appeal, the Broker must also make reasonable efforts to provide verbal notice. The written notice must include the following:

- The results of the resolution process and the date it was completed
- For appeals not resolved wholly in favor of the recipients, the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the recipient may not be held liable for the cost of those benefits if the hearing decision upholds the Broker's action

The Broker must continue the recipient's benefits if the appeal is filed timely, meaning on or before the later of the following:

- Within ten (10) days of the Broker mailing the notice of action
- The intended effective date of the Broker's proposed action.

If the final resolution of the appeal is adverse to the recipient, that is, upholds Broker's action, the Broker may recover the cost of the services furnished to the recipient while the appeal was pending, to the extent that they were furnished solely because of the requirements of 42 CFR 438.420, and in accordance with the policy set forth in 42 CFR 431.230(b).

If the Broker takes an action and the recipient requests a State Fair Hearing, the State must grant the recipient a State Fair Hearing. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the recipient by the Broker. Other information for the recipients and the providers would include:

1. A Recipient's right to file an appeal
2. The Recipient's right to request a State Fair Hearing
3. The circumstances under which a Recipient can request expedited resolution and how to request it

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

If the Broker or the State Fair Hearing officer reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Broker must authorize or provide the disputed services promptly, and as expeditiously as the recipient's health condition requires. If the Broker continues or reinstates the Recipient's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The recipient withdraws the appeal
- The recipient does not request a State Fair Hearing within ten (10) days from when the Broker mails an adverse decision.
- A State Fair Hearing decision adverse to the recipient is made, or;
- The authorization expires or authorization service limits are met.

Recipient Formal Appeals

The Broker's complaint process may not be a prerequisite to, or a replacement for the recipient's right to use the EOHHS appeal process. The Broker is responsible for the preparation of the hearing summary

and the presentation of its case. The decision of EOHHS' Fair Hearing Officer is a final and binding decision.

Recipient Advocate Position (Ombudsman)

The Broker will also be responsible for employing a Recipient Advocate (Ombudsman) for the purposes of assisting and advocating on behalf of Rhode Island Medicaid recipients. The advocate will review all the comments and direct them to the proper person, with the goal of quicker responses to and resolution of recipient concerns. The Recipient Advocate will be able to answer recipient questions about problems obtaining NEMT service or assist recipients in solving any problems that may arise from NEMT services. This position may be combined with another position such as the Complaints and Grievance Manager.

APPENDIX IX. NOTICE OF ADVERSE ACTION POLICY

The Notice of Adverse Action Policy involves providing appropriate and timely written notice to the recipient/provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested or agreed upon, or any action. Notice is not required to the recipient when an action is due to the network provider's failure to adhere to contractual requirements and there is no adverse action against the recipient.

1. The notice must explain:
    a) The action the Broker has taken or intends to take and the reason(s) for the action;
    b) The Recipient's or Provider's right to grieve, complain, or request a State Fair Hearing;
    c) The circumstances under which expedited resolution is available and how to request it;
    d) That during the state fair hearing, the recipient/provider may represent him(her)self or use legal counsel, a relative, a friend, or a spokesperson;
    e) The specific regulations that support, or the change in Federal or State law that requires the action, and
2. The notice must be in writing and must meet the following language requirements:
    a) The Broker in conjunction with EOHHS shall identify the non-English languages prevalent (i.e. spoken by a significant number or percentage of the recipient's and potential population);
    b) The Broker must make available written information in each prevalent non-English language;
    c) The Broker must make verbal interpretation services available for all languages free of charge and;
    d) The Broker must notify recipients that verbal interpretation is available for any language.
3. The notice must meet the following format requirements:
    a) Written material must use an easily understood format, and be available in alternative formats that take into consideration those with special needs.
    b) Members must be informed of the availability of alternative formats and how to access those formats.

APPENDIX X. PRICING STRUCTURE AND EXPERIENCE

Please be advised that this represents the ceiling for rates. Bidder can propose additional payment methodologies at the same rate or lower rate than the rates described herein.

Bidder must acknowledge and attest to identified pricing structure or submit a cost proposal that does not exceed the maximum limit set in the pricing structure.

Pricing Structure Attestation

Signature _____ Date _____

Print Name_____

Print Title_____

Exhibit 1

Capitation Rates and Annual Transportation Costs, by Program and Contract Period

	Contract Period 1: January 1, 2019 - June 30, 2020				Contract Period 2: July 1, 2020 - June 30, 2021[2]				Contract Period 3: July 1, 2021 - June 30, 2022[2]			
Medicaid Population	Average Monthly Enrollment	PMPM[1]	Average Monthly Capitation	Year 1 Total	Average Monthly Enrollment	PMPM	Average Monthly Price	Year 2 Total	Average Monthly Enrollment	PMPM	Average Monthly Price	Year 3 Total
Children	117,734	$ 1.24	$ 146,142	$ 2,630,563	122,176	$ 1.30	$ 158,994	$ 1,907,932	125,230	$ 1.34	$ 168,184	$ 2,018,210
Adults	163,575	$ 9.52	$ 1,556,515	$ 28,017,272	169,748	$ 9.98	$ 1,693,397	$ 20,320,760	173,991	$ 10.30	$ 1,791,275	$ 21,495,299
Aged	22,131	$ 31.77	$ 703,108	$ 12,655,942	22,966	$ 33.31	$ 764,940	$ 9,179,279	23,540	$ 34.37	$ 809,153	$ 9,709,841
Total Medicaid Population	303,440		$ 2,405,765	$ 43,303,778	314,889		$ 2,617,331	$ 31,407,970	322,762	$ 8.58	$ 2,768,613	$ 33,223,351
Non-Medicaid Population	Average Monthly Enrollment	PMPM[1]	Average Monthly Capitation	Year 1 Total	Average Monthly Enrollment	PMPM	Average Monthly Price	Year 2 Total	Average Monthly Enrollment	PMPM	Average Monthly Price	Year 3 Total
RI TANF Only[3]	30	$ 82.25	$ 2,468	$ 39,480	30	$ 82.25	$ 2,468	$ 29,610	30	$ 82.25	$ 2,468	$ 29,610
Elderly Transportation Program			$ 323,000	$ 5,168,000			$ 339,000	$ 4,068,000			$ 350,000	$ 4,200,000

Notes:

1. See Exhibits 2, 3, and 4 for development of Year 1 capitation rates.
2. Year 2 and 3 enrollment forecast and capitation rates based upon following assumptions. Actual rate to be determined by the CPI-U index for intracity transportation.

Price	3.20%	*per Consumer Price Index for all Urgan Consumer (CPI-U) for intracity transportation (January 2018)*
Enrollment	2.50%	*EOHHS estimate*

3. For TANF recipients not enrolled in Medicaid, the vendor will be reimbursed the actual cost of a monthly bus pass + 17.5%

Exhibit 2 – NEMT Capitation Rates

Non-Emergency Transportation Capitation Rates

Proposed Capitation Rates

For the 18-month Rate Period 1/1/2019 - 6/30/2020

Capitation Rate Cell	Cost Ratio	Transportation Component	Admin Component of Rate	Proposed Capitation Rates
Children 0-18	0.16	$ 0.99	$ 0.25	$ 1.24
Adults 19-64	1.21	$ 7.61	$ 1.90	$ 9.52
Aged 65+	4.04	$ 25.42	$ 6.35	$ 31.77
Composite	1.00	$ 6.28	$ 1.57	$ 7.85

Exhibit 3a – NEMT Capitation Rates

Non-Emergency Transportation Capitation Rates

For the 18-month Rate Period 1/1/2019 - 6/30/2020

Age Group: *composite*
Member Months 1,820,637

	Blended Base Period[1] 7/1/17 - 12/31/17			Trends		Forecast for Rate Period 1/1/19 - 6/30/20		
Service Type	**Util/1000**	**Avg Unit Cost**	**PMPM**	**Util/1000**	**Avg Unit Cost**	**Util/1000**	**Avg Unit Cost**	**PMPM**
Taxi	20	$ 46.00	$ 0.08	0.0%	3.2%	20	$ 48.99	$ 0.08
Bus	2,896	$ 3.47	$ 0.84	5.9%	0.4%	3,246	$ 3.50	$ 0.95
Wheel-Chair Van	187	$ 28.78	$ 0.45	-17.7%	0.0%	127	$ 28.78	$ 0.30
Ambulance	23	$ 80.40	$ 0.15	-5.6%	3.5%	20	$ 86.19	$ 0.14
Public Motor Vehicle	2,722	$ 20.06	$ 4.55	0.6%	3.2%	2,755	$ 21.36	$ 4.90
Total	5,848	$ 12.45	$ 6.07			6,168	$ 12.42	$ 6.38

Cost Reductions[2]:	$ (0.10)
Total Projected Transportation Expenses:	$ 6.28
Administrative Load:	$ 1.57
Total Capitation:	$ 7.85

Non-Emergency Transportation Capitation Rates Development

Calculation of Savings Reductions based on Transportation Expense per Year per Utilizer

For the 18-month Rate Period 1/1/2019 - 6/30/2020

	Transportation Experience:			Savings:	
	SFY 2016 7/1/15 - 6/30/16	SFY 2017 7/1/16 - 6/30/17	Targeted Reductions	SFY 2016	SFY 2017
Under $2,500	$ 7,451,152	$ 7,507,787	0%	$ -	$ -
Between $2,500 and $4,999	$ 2,936,183	$ 2,939,005	0%	$ -	$ -
Between $5,000 and $7,499	$ 3,351,376	$ 3,345,112	5%	$ 32,319	$ 32,006
Between $7,500 and $9,999	$ 2,897,468	$ 2,696,013	5%	$ 61,373	$ 57,051
Between $10,000 and $14,999	$ 3,367,796	$ 3,364,705	10%	$ 193,780	$ 193,470
$15,000 or greater	$ 1,862,301	$ 944,964	10%	$ 148,230	$ 68,496
Total	$ 21,866,275	$ 20,797,585		$ 435,702	$ 351,023
Overall Reduction in Expenses				2.0%	1.7%
Member Months				3,253,906	3,499,886
PMPM Savings				$ 0.13	$ 0.10

Non-Emergency Transportation Capitation Rates Development

Calculation of Cost Ratio

For the 18-month Rate Period 1/1/2019 - 6/30/2020

	Age Group	SFY 2016 7/1/15 - 6/30/16	SFY 2017 7/1/16 - 6/30/17	SFY 2018 7/1/17 - 12/31/17	Selected Cost Ratio
Average Monthly Costs	Children	$ 101,973	$ 101,580	$ 119,417	
	Adults	$ 1,237,497	$ 1,127,193	$ 1,030,765	
	Aged	$ 482,720	$ 504,608	$ 521,282	
	Total	$ 1,822,190	$ 1,733,381	$ 1,671,463	
Average Enrollment	Children	108,392	113,966	117,734	
	Adults	143,405	157,224	163,575	
	Aged	19,361	20,467	22,131	
	Total	271,158	291,657	303,440	
Cost per Member Month	Children	$ 0.94	$ 0.89	$ 1.01	0.16
	Adults	$ 8.63	$ 7.17	$ 6.30	1.22
	Aged	$ 24.93	$ 24.65	$ 23.55	4.03
	Total	$ 6.72	$ 5.94	$ 5.51	1.00

Exhibit 5 – ETP Proposed Monthly Payment

Elderly Transportation Program

Proposed Monthly Payment [1]

For the 18-month Rate Period 1/1/2019 - 6/30/2020

Reported Experience:

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018 through 12/31[2]
Monthly Transportation Expenses	$ 227,238	$ 250,977	$ 290,214	$ 269,432	$ 253,029

FY18 Restated	**$ 253,215.93**
Trend[3]	3.20%
Years	1.67
Total Projected Transportation Expenses:	$ 266,864
Administrative Load (Percent of Transportation):	$ 66,716.08
	$ 334,000

Notes:

1. Monthly payment is subject to adequate appropriation by Rhode Island.
2. SFY 2018 paid through December 31, 2017 completed at 100% with IBNR.
3. Trend factor based upon the CPI-U index for intracity transportation.

Attachment 1 – Historical Claims and Enrollment Activity by Month

		7/31/2015	8/31/2015	9/30/2015	10/31/2015	11/30/2015	12/31/2015
Unduplicated Riders	Children	1,581	1,626	1,689	1,698	1,702	1,642
	Adults	7,458	7,406	7,922	7,686	7,667	8,058
	Aged	2,435	2,336	2,578	2,514	2,372	2,442
	Total	11,474	11,368	12,189	11,898	11,741	12,142
Cost per Rider	Children	$ 65.24	$ 65.86	$ 65.47	$ 67.52	$ 66.53	$ 65.15
	Adults	$ 170.18	$ 164.52	$ 156.84	$ 162.58	$ 154.90	$ 161.88
	Aged	$ 203.15	$ 197.77	$ 189.15	$ 194.19	$ 188.23	$ 202.98
	Overall	$ 162.72	$ 157.24	$ 151.01	$ 155.69	$ 148.82	$ 157.07
Enrollment	Children	107,319	107,553	106,610	106,269	107,521	108,249
	Adults	145,411	143,720	145,119	138,035	142,072	144,972
	Aged	19,234	19,294	19,387	19,353	19,412	19,406
	Total	271,964	270,567	271,116	263,657	269,005	272,627

		1/31/2016	2/29/2016	3/31/2016	4/30/2016	5/31/2016	6/30/2016
Unduplicated Riders	Children	1,638	1,545	1,588	1,530	1,612	1,551
	Adults	8,056	8,203	8,957	8,435	8,548	8,712
	Aged	2,422	2,313	2,862	2,653	2,787	2,950
	Total	12,116	12,061	13,407	12,618	12,947	13,213
Cost per Rider	Children	$ 60.12	$ 58.35	$ 58.16	$ 56.78	$ 64.48	$ 62.05
	Adults	$ 156.02	$ 148.14	$ 150.42	$ 142.22	$ 138.57	$ 134.82
	Aged	$ 185.60	$ 179.47	$ 182.87	$ 186.26	$ 182.70	$ 178.53
	Overall	$ 148.97	$ 142.64	$ 146.42	$ 141.12	$ 138.85	$ 136.04
Enrollment	Children	108,291	108,476	109,570	109,891	109,867	111,089
	Adults	139,962	142,389	146,459	143,534	142,444	146,741
	Aged	19,293	19,283	19,353	19,364	19,437	19,521
	Total	267,546	270,148	275,382	272,789	271,748	277,351

		7/31/2016	8/31/2016	9/30/2016	10/31/2016	11/30/2016	12/31/2016
Unduplicated Riders	Children	1,118	1,670	1,699	1,620	1,641	1,530
	Adults	7,677	8,405	8,720	8,235	8,269	8,269
	Aged	2,628	2,829	2,889	2,900	2,804	2,610
	Total	11,423	12,904	13,308	12,755	12,714	12,409
Cost per Rider	Children	$ 60.61	$ 63.55	$ 63.33	$ 64.49	$ 63.79	$ 63.99
	Adults	$ 139.72	$ 140.18	$ 133.80	$ 138.53	$ 132.58	$ 134.27
	Aged	$ 176.79	$ 190.01	$ 182.69	$ 175.79	$ 172.54	$ 190.46
	Overall	$ 140.51	$ 141.18	$ 135.41	$ 137.60	$ 132.51	$ 137.42
Enrollment	Children	111,369	111,638	112,633	111,719	112,503	113,245
	Adults	146,448	148,668	151,465	151,550	153,720	155,613
	Aged	19,547	19,701	19,806	19,821	20,068	20,296
	Total	277,364	280,007	283,904	283,090	286,291	289,154

		1/31/2017	2/28/2017	3/31/2017	4/30/2017	5/31/2017	6/30/2017
Unduplicated Riders	Children	1,530	1,588	1,559	1,577	1,644	1,687
	Adults	8,444	8,110	8,871	8,437	8,971	9,059
	Aged	2,705	2,540	2,870	2,710	2,871	2,925
	Total	12,679	12,238	13,300	12,724	13,486	13,671
Cost per Rider	Children	$ 66.09	$ 66.66	$ 66.73	$ 64.94	$ 64.49	$ 65.78
	Adults	$ 131.94	$ 124.54	$ 130.66	$ 129.15	$ 133.40	$ 131.57
	Aged	$ 180.44	$ 172.79	$ 187.98	$ 181.05	$ 187.73	$ 184.13
	Overall	$ 134.34	$ 127.04	$ 135.54	$ 132.25	$ 136.57	$ 134.70
Enrollment	Children	113,510	114,654	115,480	116,274	116,847	117,716
	Adults	156,800	160,401	162,507	164,459	166,213	168,848
	Aged	20,484	20,705	20,978	21,221	21,380	21,599
	Total	290,794	295,760	298,965	301,954	304,440	308,163

		7/31/2017	8/31/2017	11/30/2017	9/30/2017	10/31/2017	12/31/2017
Unduplicated Riders	Children	1,576	1,657	1,798	1,780	1,796	1,796
	Adults	6,921	7,495	7,172	7,109	7,239	6,620
	Aged	2,712	3,046	2,885	2,865	2,975	2,652
	Total	11,209	12,198	11,855	11,754	12,010	11,068
Cost per Rider	Children	$ 68.80	$ 67.39	$ 70.38	$ 68.23	$ 68.79	$ 69.52
	Adults	$ 147.13	$ 149.26	$ 140.05	$ 143.38	$ 145.82	$ 146.26
	Aged	$ 180.81	$ 188.11	$ 177.14	$ 184.15	$ 184.55	$ 179.74
	Overall	$ 144.26	$ 147.84	$ 138.51	$ 141.94	$ 143.90	$ 141.83
Enrollment	Children	118,952	117,646	116,495	117,438	117,448	118,422
	Adults	169,636	167,680	160,806	162,320	159,507	161,503
	Aged	21,827	21,923	22,211	22,294	22,099	22,430
	Total	310,415	307,249	299,512	302,052	299,054	302,355

Please note that the SFY 2018 YTD data is missing individual bus passes so it understated by approx. $50,000 in expenditures each mont

Attachment 2 – Annual Transportation Expenses per Utilizers

Annual Transportation Expenses per Utilizers, SFY 2016 and SFY 2017

		SFY 2016				SFY 2017			
		Children	Adults	Aged	Total	Children	Adults	Aged	Total
Claims Paid	Under $2,500 per annum	$ 1,200,763	$ 4,616,278	$ 1,634,110	$ 7,451,152	$ 1,186,803	$ 4,683,469	$ 1,637,515	$ 7,507,787
	Between $2,500 and $4,999 per annum	$ 16,838.53	$ 2,001,697.39	$ 917,647.16	$ 2,936,183.08	$ 10,847.90	$ 1,855,940.80	$ 1,072,216.63	$ 2,939,005.33
	Between $5,000 and $7,499 per annum	$ 6,072.20	$ 2,068,887.18	$ 1,276,416.71	$ 3,351,376.09	$ 7,732.25	$ 1,894,301.39	$ 1,443,078.32	$ 3,345,111.96
	Between $7,500 and $9,999 per annum		$ 1,862,034.05	$ 1,035,433.52	$ 2,897,467.57		$ 1,658,826.86	$ 1,037,186.33	$ 2,696,013.19
	Between $10,000 and $14,999 per annum		$ 2,580,826.49	$ 786,969.48	$ 3,367,795.97	$ 13,481.30	$ 2,637,863.58	$ 713,359.75	$ 3,364,704.63
	$15,000 or greater per annum		$ 1,720,235.21	$ 142,065.30	$ 1,862,300.51		$ 793,372.75	$ 151,590.76	$ 944,963.51
Utilizers	Under $2,500 per annum	4,075	11,374	4,435	19,739	3,681	11,373	4,353	19,277
	Between $2,500 and $4,999 per annum	5	562	253	811	3	513	296	802
	Between $5,000 and $7,499 per annum	1	339	212	541	2	315	239	541
	Between $7,500 and $9,999 per annum		217	122	334		194	125	311
	Between $10,000 and $14,999 per annum		219	71	286	1	229	64	286
	$15,000 or greater per annum		68	9	76		44	9	52
Total Claims Paid		**$ 1,223,674**	**$ 14,849,959**	**$ 5,792,643**	**$ 21,866,275**	**$ 1,218,864**	**$ 13,523,775**	**$ 6,054,947**	**$ 20,797,585**
Total Utilizers		**4,081**	**12,779**	**5,102**	**21,787**	**3,687**	**12,668**	**5,086**	**21,269**

Attachment 3 – Claims Experience by Type of Service and Age Group

Type of Service Utilized by Fiscal Year

Metric	Procedure Code	Description	SFY 2016	SFY 2017
Claims	A0100	Taxi	51,579	5,909
	A0110	Bus [1]	571,749	655,517
	A0130	Wheel-Chair Van	69,662	62,831
	A0428	Ambulance	6,346	6,960
	T2003	Public Motor Vehicle	715,572	786,043
Average Cost per Claim	A0100	Taxi	$ 48.20	$ 43.80
	A0110	Bus	$ 4.24	$ 3.89
	A0130	Wheel-Chair Van	$ 28.97	$ 28.58
	A0428	Ambulance	$ 76.87	$ 77.08
	T2003	Public Motor Vehicle	$ 20.19	$ 19.92
Claims			**1,414,908**	**1,517,260**
Cost per Claim			**$ 15.45**	**$ 13.71**

Notes:

[1] Bus passes could be either: single ride, weekly pass, or monthly pass

Children

Metric	Procedure Code	Description	SFY 2016	SFY 2017
Claims	A0100	Taxi	1,027	90
	A0110	Bus	20,631	19,786
	A0130	Wheel-Chair Van	303	355
	A0428	Ambulance	152	375
	T2003	Public Motor Vehicle	6,360	7,109
Cost per Claim	A0100	Taxi	$ 57.83	$ 36.73
	A0110	Bus	$ 49.09	$ 52.10
	A0130	Wheel-Chair Van	$ 25.32	$ 24.89
	A0428	Ambulance	$ 75.40	$ 75.65
	T2003	Public Motor Vehicle	$ 20.82	$ 20.75
Claims			**28,473**	**27,715**
Cost per Claim			**$ 42.98**	**$ 43.98**

Adults

Metric	Procedure Code	Description	SFY 2016	SFY 2017
Claims	A0100	Taxi	44,439	4,478
	A0110	Bus	548,659	632,424
	A0130	Wheel-Chair Van	30,996	27,226
	A0428	Ambulance	3,472	3,131
	T2003	Public Motor Vehicle	503,646	539,454
Cost per Claim	A0100	Taxi	$ 49.73	$ 46.77
	A0110	Bus	$ 2.57	$ 2.39
	A0130	Wheel-Chair Van	$ 28.12	$ 28.14
	A0428	Ambulance	$ 77.49	$ 80.36
	T2003	Public Motor Vehicle	$ 20.04	$ 19.99
Claims			**1,131,212**	**1,206,713**
Cost per Claim			**$ 13.13**	**$ 11.21**

Aged

Metric	Procedure Code	Description	SFY 2016	SFY 2017
Claims	A0100	Taxi	6,113	1,341
	A0110	Bus	2,459	3,307
	A0130	Wheel-Chair Van	38,363	35,250
	A0428	Ambulance	2,722	3,454
	T2003	Public Motor Vehicle	205,566	239,480
Cost per Claim	A0100	Taxi	$ 35.45	$ 34.38
	A0110	Bus	$ 1.60	$ 1.50
	A0130	Wheel-Chair Van	$ 29.69	$ 28.95
	A0428	Ambulance	$ 76.15	$ 74.27
	T2003	Public Motor Vehicle	$ 20.56	$ 19.74
Claims			**255,223**	**282,832**
Cost per Claim			**$ 22.70**	**$ 21.41**

Attachment 4 – Mass Transit Experience

	Current Unit Cost
Singles	$ 2.00
Rhody 10	$ 20.00
Monthly	$ 70.00

Mass Transit Experience, by Month

as reported by vendor

	7/31/2015	8/31/2015	9/30/2015	10/31/2015	11/30/2015	12/31/2015
Singles	5,976	3,334	4,256	3,082	2,965	2,460
Rhody 10	-	-	-	-	-	-
Monthly	3,026	2,780	3,198	3,129	2,682	3,411
Medicaid	3,017	2,767	3,193	3,111	2,678	3,393
TANF Only	9	13	5	18	4	18
Total Tickets	9,002	6,114	7,454	6,211	5,647	5,871
Total Rides	66,496	58,934	68,216	65,662	56,605	70,680

	1/31/2016	2/29/2016	3/31/2016	4/30/2016	5/31/2016	6/30/2016
Singles	2,672	2,600	1,855	1,476	1,724	1,695
Rhody 10	-	-	120	513	656	652
Monthly	2,825	2,375	3,334	2,836	2,633	3,026
Medicaid	2,805	2,364	3,324	2,814	2,628	3,018
TANF Only	20	11	10	22	5	8
Total Tickets	5,497	4,975	5,309	4,825	5,013	5,373
Total Rides	59,172	50,100	69,135	60,761	57,664	65,475
	7/31/2016	**8/31/2016**	**9/30/2016**	**10/31/2016**	**11/30/2016**	**12/31/2016**
Singles	1,789	2,042	1,892	2,591	3,146	2,437
Rhody 10	534	570	566	492	536	580
Monthly	2,719	3,080	2,865	2,661	2,177	2,915
Medicaid	2,699	3,046	2,825	2,626	2,141	2,894
TANF Only	20	34	40	35	36	21
Total Tickets	5,042	5,692	5,323	5,744	5,859	5,932
Total Rides	58,839	66,492	62,022	58,271	61,361	63,637

	1/31/2017	2/28/2017	3/31/2017	4/30/2017	5/31/2017	6/30/2017
Singles	2,782	2,357	2,457	2,208	2,658	2,336
Rhody 10	187	176	289	195	249	201
Monthly	2,828	2,887	3,476	3,178	3,436	3,550
Medicaid	2,812	2,876	3,468	3,167	3,406	3,498
TANF Only	16	11	8	11	30	52
Total Tickets	5,797	5,420	6,222	5,581	6,343	6,087
Total Rides	60,277	60,977	73,422	66,743	72,623	74,341

	7/31/2017	8/31/2017	11/30/2017	9/30/2017	10/31/2017	12/31/2017
Singles	1,594	2,404	1,753	2,019	1,891	1,679
Rhody 10	147	195	131	137	148	146
Monthly	3,202	3,750	3,684	3,883	3,727	3,646
Medicaid	3,168	3,703	3,657	3,860	3,701	3,615
TANF Only	34	47	27	23	26	31
Total Tickets	4,943	6,349	5,568	6,039	5,766	5,471
Total Rides	66,369	78,379	76,088	80,364	77,171	75,329

Attachment 5 – Transportation Experience by length of trip

Transportation Experience, by Length of Trip[1] (SFY 2016 and SFY 2017 *combined*)

as reported by vendor

	Ambulance	Bus	Public Motor Vechile	Taxi	Wheelchair Van	Grand Total
Sum of Claim Count						
30+ miles	109	1,257	4,226	937	261	6,790
between 10 and 15 miles	2,168	72,675	171,548	10,674	15,641	272,706
between 15 and 20 miles	551	20,472	44,109	5,775	2,969	73,876
between 20 and 30 miles	281	8,637	17,965	7,199	1,964	36,046
Under 10 miles	8,066	855,480	982,965	25,846	83,156	1,955,513
unknown	2,131	268,745	280,690	7,057	28,502	587,125
Sum of Paid Amount						
30+ miles	$ 15,774	$ 3,850	$ 258,034	$ 138,020	$ 18,027	$ 433,705
between 10 and 15 miles	$ 175,459	$ 178,684	$ 4,253,750	$ 572,690	$ 536,848	$ 5,717,431
between 15 and 20 miles	$ 49,144	$ 323,800	$ 1,268,805	$ 462,300	$ 118,413	$ 2,222,462
between 20 and 30 miles	$ 27,129	$ 99,905	$ 649,913	$ 763,999	$ 92,862	$ 1,633,808
Under 10 miles	$ 603,154	$ 3,889,450	$ 18,919,490	$ 725,369	$ 2,306,382	$ 26,443,845
unknown	$ 153,694	$ 479,051	$ 4,756,387	$ 82,752	$ 741,439	$ 6,213,323
Total Sum of Claim Count	**13,306**	**1,227,266**	**1,501,503**	**57,488**	**132,493**	**2,932,056**
Total Sum of Paid Amount	**$ 1,024,354**	**$ 4,974,740**	**$ 30,106,379**	**$ 2,745,130**	**$ 3,813,971**	**$ 42,664,574**

Note:

1. Length of trip calculated based on distance between Zip Code of Pick Up and Drop Off location.

MODEL CONTRACT

BETWEEN

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

TRANSPORTATION BROKER

(Please be advised that this represents a draft/ model contract only and does not represent the final contract for signature. Please review the document for base requirement. Please be advised that all attachments will need to be updated).

TABLE OF CONTENTS

ARTICLE I: DEFINITIONS

ARTICLE II: TRANSPORTATION PROGRAM STANDARDS

2.1 GENERAL PROVISIONS
2.2 LICENSURE, ACCREDITATION, CERTIFICATION
2.3 TRANSPORTATION PROGRAM ADMINISTRATION
2.4 TRANSPORTATION PROGRAM ELIGIBILITY AND PROGRAM ENROLLMENT
2.5 RECIPIENT ENROLLMENT AND DISENROLLMENT
2.6 LEVELS OF SERVICE
2.7 COORDINATION OTHER HEALTH/ SOCIAL SERVICES AVAILABLE TO RECIPIENTS
2.8 TRANSPORTATION PROVIDER NETWORKS
2.9 TRANSPORTATION PROVIDER AND VEHICLE REQUIREMENTS
2.10 BUSINESS OFFICE AND CALL CENTER LOCATION
2.11 TRANSPORTATION RECIPIENT SERVICES
2.12 TRANSPORTATION PROVIDER SERVICES
2.13 PAYMENTS
2.14 CONTRACT TERMS AND CONDITIONS
2.15 INTERPRETATIONS AND DISPUTES
2.16 CONTRACT AMENDMENTS
2.17 GUARANTEES, WARRANTIES, AND CERTIFICATIONS
2.18 PERSONNEL
2.19 RECORDS RETENTION
2.20 PERFORMANCE STANDARDS AND DAMAGES
2.21 OPERATIONAL DATA REPORTING
2.22 COMPLIANCE
2.23 GRIEVANCE AND APPEALS
2.16 ANNUAL COMPLIANCE AUDIT
2.17 INSPECTION OF WORK PERFORMED
2.18 CONFIDENTIALITY OF INFORMATION
2.19 TERMINATION OF THE CONTRACT
2.20 OTHER CONTRACT TERMS AND CONDITIONS

ADDENDUM I
FISCAL ASSURANCES

ADDENDUM II
NOTICE TO EOHHS BROKERS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

ADDENDUM III
NOTICE TO EOHHS' BROKERS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OFTHE REHABILITATION ACT OF 1973

ADDENDUM IV
DRUG-FREE WORKPLACE POLICY

ADDENDUM V
DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE

ADDENDUM VI
SUB BROKER COMPLIANCE

ADDENDUM VII
CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

ADDENDUM VIII
INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS

ADDENDUM IX
CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS

ADDENDUM X
CERTIFICATION REGARDING LOBBYING

ADDENDUM XI
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS SUPPLEMENTAL TERMS AND CONDITIONS FOR CONTRACTS AND SUBAWARDS FUNDED IN WHOLE OR IN PART BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, PUB. L. NO. 111-5

ADDENDUM XII
BUSINESS ASSOCIATE AGREEMENT

ADDENDUM XIII
REQUEST FOR PROPOSAL SCOPE OF WORK

ADDENDUM XIV
BUDGET

ADDENDUM XV
FEDERAL SUBAWARD REPORTING

ADDENDUM XVI
LIQUIDATED DAMAGES

ADDENDUM XVII
EQUAL EMPLOYMENT OPPORTUNITY

ADDENDUM XVIII
BID PROPOSAL

ADDENDUM XIX
CORE STAFF/BROKER'S LOCATION

ATTACHMENT A
BROKERS' CAPITATION RATES SFY 2019

ATTACHMENT B
BROKER'S INSURANCE CERTIFICATES

ATTACHMENT C
RATE-SETTING PROCESS

ATTACHMENT D
PERFORMANCE GOALS

ATTACHMENT E
REPORTING CALENDAR

ATTACHMENT F
BORDER COMMUNITIES

ATTACHMENT G
COVERED SERVICES FOR TRANSPORTATION

ARTICLE I: DEFINITIONS

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

ABUSE
TP and/or Broker practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the State of Rhode Island, medical harm to the recipient, or a pattern of failing to provide medically necessary services required by this contract. (Recipient practices that result in unnecessary cost to the State of Rhode Island also constitute abuse).

ACCOUNTABLE ENTITY (AE)
An Accountable Entity (AE) is Medicaid's version of an Accountable Care Organization (ACO) where a provider organization is accountable for quality health care, outcomes, and the total cost of care of its population.

ACTION
The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the EOHHS; the failure of a Broker to act within the timeframes for authorization decisions set forth in this contract.

ADDITIONAL STOP
All trips have one pickup point and one drop-off point. An additional stop is a pickup point or drop-off point other than the initial pickup and final drop-off points. Additional stops occur when multiple recipients are transported during a single trip or there is a scheduled pharmacy stop.

ADMINSTRATIVE HEARING
A formal review by EOHHS that occurs after the Broker and a recipient have failed to find mutual satisfaction concerning decisions rendered such as denials, reductions, suspensions, or terminations of service.

AGREEMENT OR CONTRACT
This document is referred to as an Agreement or Contract between EOHHS and the Broker.

AMBULANCE
An air or ground vehicle for transporting the sick and injured that is:

A. Equipped and staffed to provide medical care during transit;

B. For the ground vehicle, operated as a ground ambulance under the authority and in compliance with promulgated regulations of the Rhode Island Department of Health;
C. Registered as such by the Rhode Island Division of Motor Vehicles; or
D. For the air vehicle, registered and certified as an air ambulance by an appropriate authority in which the aircraft is located; and,
E. May be used for both Emergency and Non-Emergency Transportation purposes.

AMBULANCE SERVICE TYPES

Basic Life Support (BLS) Nonemergency:

Basic life support nonemergency (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician basic (EMT-Basic). The ambulance service and personnel must comply with all relevant RI General Laws and DPH Regulations. Basic life support level services are those performed by personnel certified in Rhode Island as Emergency Medical Technicians (EMT).

Advanced Life Support, Level 1 (ALS):

Advanced life support, level 1 (ALS) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention. An ALS assessment charge is only relevant and reimbursable in an emergency response, which will not be administered by the Broker. An advanced life support (ALS) intervention is a procedure that is in accordance with State and local laws, required to be done by an advanced emergency medical technician (AEMT) or Paramedic. The ambulance service and personnel must comply with all relevant RI General Laws and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements. Advanced Life Support services are those performed by personnel certified in Rhode Island as an Advanced Emergency Medical Technician (AEMT) or Paramedic.

These ambulance services are only available to Medicaid recipients.

AMERICANS WITH DISABILITIES ACT (ADA) of 1990

A comprehensive, Federal civil rights law that prohibits discrimination against individuals with disabilities in employment, state and local government programs and activities, public accommodations, transportation, and telecommunications.

APPEAL

A procedure through which recipients can request a re-determination of Broker actions including, but not limited to, service authorization, denial of service or reduction in the level or mode of service.

ASSISTANCE

The physical or communicative help provided by a driver or a person employed by the TP to enable

qualified recipients to enter or exit a vehicle or residence.

AUTHORIZATION
Prior Authorization: Prior authorization is the determination made by the Broker or EOHHS where the Broker verifies eligibility for services and determines the least expensive, medically necessary mode of transportation. This is the primary process for administering the Brokerage service and must be administered to verify client eligibility at the time of the transportation request. and at monthly intervals when the recipient requests multiple trips that span more than one month. EOHHS also requires the Broker to verify appointments before scheduling a trip.

AVL
Automatic Vehicle Location is a means for automatically determining and transmitting the geographic location of a vehicle. This vehicle location data, from one or more vehicles, may then be collected by a vehicle tracking system to manage an overview of vehicle travel.

BORDER COMMUNITIES
Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medical Assistance Program, eligible for transportation. A list of those communities is in Attachment F. Out-of-state service restrictions and prior authorization requirements are not imposed on TPs for these communities.

BROKER
The entity that contracts with EOHHS to deliver Medicaid transportation, ETP and TANF transportation services.

CAPITATION PAYMENT
Capitation Payment means a payment for each premium rate category EOHHS makes periodically to Broker on behalf of each Medicaid recipient for the provision of transportation service under this agreement. EOHHS makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
The Centers for Medicare and Medicaid Services (CMS) is a division within the United States Department of Health and Human Services. CMS oversees the Medicaid and State Children's Health Insurance Program (SCHIP) programs.

COMPLAINT
A written or verbal complaint that expresses dissatisfaction with service delivery or any matter other than an "action" as defined herein.

COMPLAINT TIERS

1. Tier one complaints – Issues/incidents involving safety, negligence and injury that require immediate attention. Such issues include injury requiring medical care, accidents resulting in injury, evidence of weapon, assault, incidents that require police assistance, sexual harassment, and other incidents where the recipient in danger.
2. Tier two complaints – Issues/incidents involving service issues such as accidents without injury (with/without police assistance), wheelchair tie-down issues (not resulting in injury), unresolved disagreements, habitual driver no-show/late/rudeness and other disruptions and questionable behaviors
3. Tier three complaints – Issues/incidents involving isolated service or behavior issues such as loud music, isolated provider/recipient late, vehicle cleanliness

CONTRACT SERVICES

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

CO-PAYMENT

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

COVERED SERVICES

Covered Services mean the transportation services packages described in this Agreement.

CURB-TO-CURB LEVEL OF SERVICE

Transportation of the recipient from the outside door of his/her residence to the curb in front of the destination, including return trip. The driver may assist the individual to get in and out of the vehicle. The driver does not enter the residence or provider's office.

DATA WAREHOUSE

A data storage system that consolidates data provided by EOHHS Brokers.

DAYS

Days mean calendar days unless otherwise specified.

DENIAL

Any rejection, in whole or in part, of a transportation service for a recipient.

DOOR-TO-DOOR LEVEL OF SERVICE

Transportation of the recipient from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the

transport of the recipient from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be ADA (Americans with Disabilities Act) accessible. The driver does not enter the residence or provider's office.

DXC.TECHNOLOGY (DXC)
EOHHS fiscal agent contracted to process and adjudicate claims to support the Rhode Island Medical Assistance Program with which network providers must enroll.

EFFECTIVE DATE OF ELIGIBILITY
EOHHS's administrative determination of the date an individual becomes eligible for RI Medicaid programs.

EMERGENCY AMBULANCE TRIP
An ambulance trip made because of an emergency which has as its destination a:

A. Hospital emergency room; or
B. General hospital or psychiatric facility where a nonscheduled admission results; or
C. General hospital or psychiatric facility where an emergency admission results after qualified transportation recipients were seen at a hospital emergency room; or
D. Second facility because an emergency medical service was not available at the original emergency room;

EMERGENCY MEDICAL TRANSPORTATION
Ambulance services for an emergency medical condition.

EOHHS
The Rhode Island Executive Office of Health and Human Services

ESCORT
An individual any age who accompanies the recipient to medical visits for support and assisting in comprehension of medical instruction from medical providers

FRAUD
Intentional deception or misrepresentation, or reckless disregard or willful blindness by a person or entity with the action could result in an unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable federal or state law.

GRIEVANCE
An expression of dissatisfaction about any matter other than the appeal of actions, a formal complaint.

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

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

HEALTH INSURANCE

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

HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY RULE

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT SECURITY RULE

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

HEALTH PLAN, PLAN, OR HMO

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

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

INSIGHT PROGRAM
Program offered in RI for individuals who are sight impaired and/or presently registered with the INSIGHT agency.

INTERCHANGE (IC)
EOHHS's Medicaid Management Information System operated by DXC.

INTEGRATED ELIGIBILITY SYSTEM (IES)
The sole comprehensive database of the EOHHS' recipient eligibility information.

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

MARKETING
Marketing means any communication, from the Broker to a recipient who is not engaged in transportation services that can reasonably be interpreted as intended to influence the recipient to engage.

MARKETING MATERIAL
Marketing material means materials that are provided in any medium, by or on behalf of the Broker that can reasonably be interpreted as intended to influence potential recipients.

MEDICAID
The Rhode Island Medical Assistance Program operated by EOHHS under Title XIX of the Federal Social Security Act and related State and Federal rules and regulations.

MEDICAID MANAGED CARE ORGANIZATION (MCO)
An insurer, health care center, or other organization that provides, offers, or arranges for coverage of health services needed by plan recipients and uses utilization review and a network of participating providers to administer the provision of health care. For purposes of this contract, "managed care organization" refers to a managed care organization that is under contract with EOHHS to provide contract services to enrolled members.

MEDICALLY NECESSARY /MEDICAL NECESSITY
The RI Medicaid Program provides payment for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" 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 detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and medically necessary setting and shall not be provided solely for the convenience of the recipient, caretaker, or service provider.

MEDICALLY NECESSARY MODE OF TRANSPORTATION
The least expensive type of transportation that medically meets the physical and medical circumstances of qualified recipient.

MILEAGE REIMBURSEMENT
Mileage Reimbursement refers to compensating the Medicaid recipient, friend, acquaintance of family recipient on a per-mile basis for transporting an eligible Medicaid recipient to a Medicaid covered service. Additionally, mileage reimbursement is not allowable for the ETP.

MULTI-LOAD
A ride shared by more than one eligible recipient, prior-authorized by the Broker in accordance with EOHHS policies.

NETWORK
The transportation providers that a broker has contracted with to provide transportation services are a network. These providers are called "network providers" or "in-network providers."

NETWORK PROVIDER
Network provider is any provider, group of providers or entity that has a provider agreement with Broker, or a sub broker, and received federal funding directly or indirectly to order, refer or render transportation services as a result of this contract.

NON-EMERGENCY AMBULANCE TRIP
A pre-arranged and prior authorized ambulance trip to a non-emergency medical service.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)
Approved transportation services for Medicaid recipients to receive or to return from receiving medically necessary and non-emergency medical services covered by the Rhode Island Medicaid program.

NORMAL BUSINESS HOURS
Normal business hours for the Broker's RI business office will be 8 a.m. to 6 p.m., Monday through Friday except for ten (10) State holidays: New Year's Day, Martin Luther King Day, Memorial Day, July 4th, Victory Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

NO SHOW
Recipient: The failure of a recipient to utilize a scheduled transportation service.
Transportation Provider: The failure of a TP to pick up a recipient as scheduled.

OUT-OF-STATE TRIP
A trip originating and/or ending outside Rhode Island that involves the transport of a patient to or from a medical provider that is neither located in Rhode Island nor an approved border community.

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

POTENTIAL RECIPIENT
A Medicaid eligible individual who has not yet engaged with the Broker.

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

RECIPIENT
A transportation beneficiary/recipient.

RECIPIENT ENCOUNTER DATA
Recipient encounter data is information relating to the receipt of any item or services by the recipient under this contract. Encounter data is required in an 837 format for Medicaid recipients. For ETP, and TANF recipients, utilization reports are required.

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

RIDE PROGRAM
The RIde Program, RIPTA'S ADA Comparable Paratransit Service required by the Americans with Disabilities Act (ADA). Paratransit service provided under ADA is available for an individual whose disability either prevents independent use of the fixed route system or prevents travel to or from bus stops.

RIDE-SHARE PROGRAM OR VEHICLE
Vehicle-for-hire program such as Uber and Lyft.

RHODE ISLAND PUBLIC TRANSPORTATION AUTHORITY (RIPTA)
RIPTA is a quasi-public, independent authority that is authorized to operate public transit services throughout the state of Rhode Island.

RISK
The possibility of monetary loss or gain by the Broker resulting from service costs exceeding or being less than payments made to it by EOHHS.

SERVICE ANIMAL
Any guide dog, signal dog, therapy animal or other animal trained to provide assistance to an individual with a disability.

SIGNIFICANT INCIDENT
Any incident that results in serious injury, serious adverse treatment, death of a service user, or serious impact on service delivery as defined by EOHHS's policies and procedures or any incident that a prudent person could have expected to result in any of the above.

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

STRETCHER VAN
Stretcher van service is a regulated mode of NEMT which may be provided to an individual who cannot be transported in a livery vehicle, taxi, or wheelchair van due to being non-ambulatory and must be transported lying flat. Stretcher van personnel are not required or authorized to provide medical monitoring, medical aid, medical care, or medical treatment of passengers during their transport. Individual passengers may self-administer oxygen. Stretcher van is only available to Medicaid Recipients.

SUBCONTRACT
Any written agreement between a Broker and another party to fulfill any requirements of a contract.

SUB BROKER
Sub broker means an individual or entity that has a contract with the Broker that relates directly or indirectly to the performance of the Broker obligations under this contract with the State.

SUBSTANCE USE DISORDER (SUD)
A condition in which the use of one or more substances leads to a clinically significant impairment or distress. SUD involves the overuse of, or dependence on, a drug or substance leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others.

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

TANF (RI WORKS) Program
The TANF (RI WORKS) program provides financial and employment assistance to eligible pregnant women and parents with children. Most RI Works recipients are eligible for Medicaid once they apply. Transportation reimbursement or bus passes are available to support preparation for employment.

TAXI
A "vehicle for hire" operating as a taxi as under the authority and in compliance with promulgated regulations of the RI Public Utilities Commission and registered as such by the Department of Motor Vehicles.

THIRD-PARTY
Any individual, entity or program that is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State plan.

TITLE XIX
The provisions of 42 United States Code Section 1396 et seq., including any addenda thereto. (See Medicaid.)

TRANSPORT TIME
The expected shortest duration required to transport an individual from a pick-up location to a drop off location without additional stops.

TRANSPORTATION PROVIDER
An entity that transports recipients.

TRANSPORTATION RECIPIENT
A person eligible for and in need of transportation services.

TRANSPORTATION PROVIDER AGREEMENT
The signed written contract or agreement between EOHHS's transportation Broker and the Provider of Transportation services.

TRANSPORTATION VEHICLE
A vehicle that is:

A. Constructed to carry passengers;
B. Operated under the authority and in compliance with the statutes and regulations of the Department of Transportation and/or a transit district and the Division of Motor Vehicles; and
C. Used for the transportation of recipients.

URGENT TRIP
Trips provided within 48 hours of scheduling as a result of a recipient's need for medical care due to illnesses or injuries which require prompt attention but are not of such seriousness as to require the services of an emergency room. This includes trips to SUD treatment facilities.

UTILIZATION MANAGEMENT
The prospective, retrospective, or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to an individual within the State of Rhode Island receiving benefits or entitled to receive benefits under applicable programs.

WAITING TIME
The time that a vehicle is waiting at a medical provider's facility, to which the TP transported the recipient, in order to transport the recipient to another destination, during the same trip or the time that a vehicle is waiting at the pick-up location, whether a medical provider's facility or the recipient's residence, in order to transport to or from a medical appointment.

WHEELCHAIR VAN
A. A motor vehicle (sometimes referred to as a "wheelchair accessible livery van") that is:
1) Specifically equipped to carry persons who are mobility challenged or otherwise

rely on wheelchairs; and

2). Used exclusively for the transportation of non-ambulatory patients in wheelchairs that can be appropriately secured for transport according to vehicle and wheelchair design standards; and

3). Registered as such by the Division of Motor Vehicles.

B. A motor vehicle operated as an invalid coach under the authority and in compliance with promulgated regulations of the RI Division of Emergency Medical Services or alternatively operated as a wheelchair accessible livery vehicle by the Department of Transportation and registered as such by the Division of Motor Vehicles.

ARTICLE II: TRANSPORTATION PROGRAM STANDARDS

GENERAL PROVISIONS

The Broker shall implement a centrally-managed human service transportation system that provides consumers with access to high-quality non- emergency medical transportation services by using the most cost-effective and Medically necessary delivery mode available. The Broker shall arrange and secure transportation for eligible recipients who do not have transportation. The Broker shall provide the least expensive means of transportation possible that shall meet the recipient's medical needs and will be delivered in a responsive and timely manner. The Broker shall provide opportunities and incentives to improve overall cost effectiveness and program efficiency.

The Executive Office of Health and Human Services (EOHHS) shall perform coordinated oversight and monitoring of the Broker to ensure program goals and standards are being met.

WHEREAS the Broker is willing and qualified to provide services, the parties hereto do mutually agree as follows:

EOHHS and the Broker will work collaboratively to build a successful program that will achieve the state goals and requirements of EOHHS. EOHHS and the Broker will engage in a planning period initiating at the start of this contract to address opportunities for program improvements.

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

In return for Capitation Payments, the Broker agrees to provide eligible recipients with the services described in this ARTICLE II: PROGRAM STANDARDS and subsequent Attachments hereto.

Broker shall furnish or arrange for the personnel, facilities, equipment, supplies, and other items and expertise necessary for, or incidental to, the provision of services specified below, at locations including, but not limited to, the entire State of Rhode Island, to recipients eligible for Broker services.

The provisions and conditions of this contract are subject to amendments based on changes to applicable Federal and State laws and regulations which govern this document. The Broker shall work with EOHHS to implement the changes.

The Broker's written response and attachments to RFP# XXXXXX, Transportation Brokerage Services, will be included as part of the scope work that will be implemented by the broker. Any previous attachments are to be finalized and sent to EOHHS 15 days prior to the start date of the contract for review and approval.

The following are items in the scope of work that will be expected of The Broker:

LICENSURE, ACCREDITATION, CERTIFICATION

The Broker shall have a duly licensed, non-residential administrative office ("central business office") that is reasonably accessible to the EOHHS Office (located in the Pastore Complex in Cranston, RI).

Obtain and keep on file copies of required permits and licenses from the municipalities in which transportation providers operate.

Require transportation providers (TPs) to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activities to be performed under this Contract.

TRANSPORTATION PROGRAM ADMINISTRATION

Broker agrees to maintain sufficient administrative staff and organizational components to comply with all program standards described herein. At a minimum, Broker agrees to include each of the functions noted herein.

Broker may combine functions or split the responsibility for a function across multiple positions, as long as it can demonstrate that the duties of the function are being carried out. Similarly, Broker may contract with a third party (sub broker) to perform one or more of these functions, subject to the sub broker conditions described in this Agreement.

Executive Management

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

Key management staff must be located in Rhode Island for ease of meeting with State staff, medical providers, facilities and other stakeholders.

Other Administrative Components

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

- Accounting and Budgeting Function
- Recipient Services Function
- Provider Services Function
- Quality assurance, prior authorization, concurrent review and retrospective review
- Grievance and Appeals Function
- Claims Processing Function
- Management Information System

- Program Integrity and Compliance

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

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

EOHHS Readiness Review Responsibilities
EOHHS will conduct a Readiness Review of the Broker that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing and service provision to recipients. EOHHS will conduct the Readiness Review to verify the Broker's assurances that the Broker is ready and able to meet its obligations under the Contract.

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

- Transportation Provider composition and access;
- Staffing, including key personnel and functions directly impacting recipients;
- Recipient Services capability (materials, processes and infrastructure, e.g., call center capabilities);
- Comprehensiveness of quality management/quality improvement and Utilization Management strategies;
- Internal Grievance and Appeal policies and procedures;
- Fraud and abuse and program integrity policies and procedures;
- Financial solvency; and
- Information systems, including Claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data.

No individual shall be provided transportation by the Broker until EOHHS determines that the Broker is ready and able to perform its obligations under the Contract as demonstrated during

the Readiness Review.

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

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

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

The Broker must provide EOHHS with corrections requested by the Readiness Review.

TRANSPORTATION PROGRAM ELIGIBILITY

Successful bidders shall be required to cover the following groups:

Medicaid Eligible and Enrolled Recipients

The transportation program is a service offered to all Medicaid recipients who need medical services. It provides non-emergency transportation services for recipients to medical appointments and other Medicaid covered services including transportation to the Rhode Island VA medical centers. This service is offered as a last resort when the Medicaid recipients are not able to provide his/her own transportation or receive transportation from a family recipient, friend, or other party.

Eligible Medicaid recipients include adults and children who live in a community setting and are receiving medical assistance benefits through RI Medicaid's managed care and fee-for-service arrangements.

Temporary Assistance for Needy Families (TANF)

All recipients of the TANF Program (also known as RI Works) are eligible to receive a monthly bus pass. This bus pass is provided to assist these recipients to pursue employment opportunities or job training.

Non-Medicaid Elderly Population

The Elderly Transportation Program (ETP), pursuant to EOHHS Rules and Regulations Section 1360.06 –1360.08, provides transportation for individuals aged 60 years and older who are not

getting transportation from the RIPTA RIde Program, the RIPTA Free Bus Program, or from the Americans with Disabilities Act (ADA) Program. The Broker will be required to screen all elderly who request services under this program to assess their eligibility for the RIPTA RIde Program or the ADA Program.

RECIPIENT ENROLLMENT AND DISENROLLMENT

Eligibility Procedures

Medicaid transportation services delivered by the Broker are only reimbursable when the recipient is being transported to or from a Medicaid covered service delivered by a Medicaid provider.

Medicaid transportation services shall be provided if:

- Recipient has a medical condition that prevents them from using fixed route bus services; and /or
- Origin/destination address is more than 1/2 mile from the bus route;
- Recipient has an appointment per Broker's confirmation; and
- Transportation services delivered by the broker are only reimbursable when the person meets the criteria for the elderly transportation program, described elsewhere in this Agreement.

Medicaid and TANF recipient eligibility verification status shall be conducted for each trip by using at the minimum an EOHHS eligibility file (for example, 834 enrollment report). The Broker must verify recipient eligibility regardless of who initiates the request. The Broker shall be solely responsible for payment for any trips scheduled for ineligible individuals.

EOHHS will supply the Broker a file of eligible recipients on a monthly basis. Broker agrees to accept recipient information in the data format submitted by EOHHS.

Transportation services must be available on a non-discriminatory basis to eligible recipients irrespective of the regions, communities, or neighborhoods they live in or their age, race, religion, creed, national origin, sexual orientation, gender, ability, health status or based on others with whom they live.

Challenging Behavior

The Broker shall provide transportation to and from necessary medical services is available, timely and safe for all eligible recipients.

The Broker shall not deny transportation services because the recipient exhibits challenging behavior patterns (i.e. unreliable, unpleasant, unruly, uncooperative, threatening, dangerous, and illegal behavior), and therefore must establish policy/procedures to assure reliable transportation for such recipients. This includes recipients that don't schedule appointments or habitually don't keep appointments; and recipients that blatantly abuse the transportation benefit. In certain circumstances, the Broker may require the recipient to call in on the day of

the ride to verify that they still need the transportation or take other measures that may entail providing an attendant to ensure that the recipient can be safely transported.

Such policies and procedures must address strategies for dealing with recipients with such challenges. Concerns for safety of self or others such as threats to self or others, drug or alcohol use, possession of weapons, any assaultive behavior, behavior resulting in police intervention and or illegal behavior, will require a review by the Broker and EOHHS for suitable course of action for transportation. A transportation provider may, upon consultation with the Broker, refuse to transport any person who is a threat to the health, safety, or welfare of the driver or other passengers, or who prevents or inhibits the vehicle from being operated in a safe manner.

- The Broker shall allow and/or arrange for no more than one attendant to accompany any recipient who requires one during transportation. If the recipient has no attendant available, the Broker shall arrange and procure one for the recipient at the recipient's residence. The Broker shall ensure that an attendant accompanies all children under the age of 18.
- The Broker shall allow adult recipients who need transportation to their own medical appointments to have no more than one child accompany them during transportation.
- The Broker shall identify and plan for the special needs of passengers (e.g. cannot be left alone, cannot identify him/herself by name);
- The Broker shall be responsible for informing and educating recipients and key stakeholders including, health care providers, provider associations, community-based organizations and consumer representatives about the transportation brokerage services.
- The Broker shall emphasize the availability of transportation services, eligibility for these services, the authorization process for single trips and standing orders, medical documentation of need, and how to access and use these services properly.
- The Broker shall maintain and operate a telephone device (TDD) for the deaf and hard of hearing callers who need such a device.

Process Requests for Disenrollment

When a recipient has demonstrated a pattern of continued noncompliance with transportation guidelines, (e.g. no-shows or disruptive behavior), a TP may submit a request to the Broker for disenrollment.

All contracted TPs shall specify the reason(s) (i.e. repeated no shows, disruptive behavior) for which the Broker may request refusal to provide transportation services to a recipient. The Broker shall be required to demonstrate how the recipient's continued enrollment seriously impairs the TP's ability to furnish transportation services to the particular recipient. Contracted TPs shall submit to the Broker detailed documentation of a recipient's continued non-compliance with the TP's transportation guidelines. The Broker will review all detailed submissions and make a recommendation to EOHHS regarding a recipient's continued access to transportation services. All requests for disenrollment shall be made in writing to EOHHS for approval. The TP is to continue to provide transportation services to the recipient until notified by EOHHS on the 834 file that the

recipient has been removed.

LEVELS OF SERVICE

The broker will be responsible for providing two levels of transportation for both Medicaid and ETP recipients:

Curb-to-Curb Service: (see definitions section)

Door to Door Service: (see definitions section)

The recipient must contact the Broker to request transportation services prior to a non-urgent, scheduled appointment, more than 48 hours from the appointment. Brokers shall maintain an advanced scheduling timeframe to which they optimally respond and deliver recipients in a timely manner to their appointments. Advance scheduling is mandatory for all transportation services except urgent care and follow-up appointments that occur where the timeframe does not allow advance scheduling.

The Broker must ensure that transportation services are available 24 hours per day, 7 days per week, and 365 days a year.

Attendants and Other Passengers

The Broker must determine if the recipient requires an attendant or is accompanied by a child.

An attendant is required for children under the age of 18. In some cases, such as when a recipient is not ambulatory or mentally competent, the transportation provider may require an attendant for an adult passenger.

Covered Services and Modes of Transportation

Medicaid Population

Recipients eligible for Medicaid are eligible to receive transportation from any of the following modes, as medically determined by the needs of the recipient:

- Public Transit (bus)
- Taxi
- Ride-Share Program (Uber/Lyft)
- Public Motor Vehicle
- Multi-Passenger Van
- Wheelchair Van
- Ambulance (stretcher van, ALS/BLS)
- Mileage Reimbursement

Public transit shall be the mode of transportation when both the recipient and the Medicaid

service provider are located within one-half (1/2) mile of an established bus stop. The Broker must request documentation of medical necessity from the recipient's medical/behavioral health provider for all transportation modes except for public transit (bus) and mileage reimbursement. Mileage Reimbursement is provided for prior-authorized non-emergency medical transportation to a Medicaid recipient's covered service appointment. The recipient, friend, or family recipient responsible for transporting the Medicaid recipient qualifies for mileage reimbursement if they are unable to provide transport without financial assistance.

If medically (physical or mental health) justified and communicated during the reservation, an additional person can be permitted to accompany a recipient. An escort must accompany all children under the age of 18 years. Adult recipients who need transportation to their own Medicaid covered service may have a child accompany them.

A list of covered services for transportation services is provided in Attachment G. This list is subject to change.

ETP

ETP, pursuant to EOHHS Rules and Regulations Section 1360.06 –1360.08, provides transportation for individuals aged 60 years and older who are not getting transportation from the RIPTA RIde Program, the RIPTA Free Bus Program, or from the Americans with Disabilities Act (ADA) Program. Service provision is contingent upon available state funding.

- Please refer to the EOHHS Rules and Regulations for acceptable modes of transportation.

ETP does not provide ambulance transportation, including stretcher van, ALS, and BLS. Mileage reimbursement is not available for the ETP program.

A full description of ETP is at:
http://sos.ri.gov/documents/archives/regdocs/released/pdf/EOHHS/8334.pdf

TANF

This population is eligible for public mass transit (bus) passes only.

COORDINATION WITH SERVICES AND OTHER HEALTH/SOCIAL SERVICES AVAILABLE TO RECIPIENTS

The Broker shall coordinate or consolidate as many service delivery functions as possible, such as call centers, trip assignment functions and eligibility verification. The Broker shall ensure call center staff are able to assign trips for all populations, verify recipients' eligibility, and determine least costly mode of transportation based on medical necessity.

Transportation service region includes all cities and towns in the State of Rhode Island. Transportation also includes transport to authorized border communities and approved out-of-state

trips. ETP provides transportation to border communities if the destination is the closest to the recipient's home. Prior approval in accordance with existing EOHHS policies is needed for out of state medical trips. Prior approval is not needed for allowable transportation to authorized border communities. A list of authorized border communities is included in Attachment F.

TRANSPORTATION PROVIDER NETWORK

The Broker shall establish a sufficient TP network with the resources necessary (numbers and types of vehicles and drivers in each city or county) to deliver services to recipients. The Broker shall implement, operate, and maintain an adequate network of contracted TPs that meet quality of service delivery and performance expectations. The Broker shall document its TP selection criteria and procedures to verify the financial stability of all selected TPs.

The Broker shall maintain, in detail, contingency plans for unexpected peak transportation demands and back-up plans when notified that a vehicle is excessively late or is otherwise unavailable for service.

The Broker shall maintain procedures to ensure vehicle availability is adequate to fulfill the required standards of promptness and minimal ride time.

The Broker shall be responsible for identifying, recruiting, and negotiating sufficient service agreements with TPs to meet the needs of transportation recipients.

If the Broker implements an incentive program for contracted TPs, they shall present the terms of the proposed incentive program to EOHHS, provide a detailed description of the proposed incentive program including how to fund the incentive program, and the type, content and frequency of incentive program reports that will be provided to EOHHS.
The Broker shall establish a network to ensure that recipients in the community are well served, including developing a competitive marketplace that has a variety of TPs for each mode of transportation.

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

EOHHS reserves the right to direct the Broker to terminate any service agreement with a TP when EOHHS determines this to be in the best interest of the State.

The Broker must ensure its network is capable of meeting the following EOHHS requirements:

- Provide quality transportation service delivery to all eligible populations;
- Ensure that TPs are willing and able to serve all recipients including those with physical and mental disabilities;

- Establish and incentivize a comprehensive transportation network that ensures that all recipients are served equally;
- Address TPs' challenges working in diverse home and geographical environments;
- Collaborate and communicate with the MCOs to provide safe, timely and coordinated transportation;
- Focus on program integrity, Fraud Waste and Abuse prevention and detection;
- Develop policies and procedures for authorizing, scheduling, managing, and making payment for transportation services;
- Subcontract with TPs and ensure access to high-quality transportation services.

Transportation Provider Contracts

The Broker shall document its process for negotiating contracts with TPs. All contracts must be in writing. Broker must ensure that TPs are in compliance with all recipient protections. The Broker shall have a written plan for monitoring and oversight of performance of TPs, including provisions for assessing TP compliance and corrective actions and/or termination. Broker is responsible for performance of all duties under this Contract and the State will consider the Broker to be the sole point of contact with regard to contractual matter. The Broker shall:

- Develop and enhance the existing TP network
- Create alternative options for transportation, including services provided by volunteer networks, community-based organizations, community health teams, on-demand transportation etc.
- Close collaboration with Medicaid Managed Care Organizations (MCOs) and Accountable Entities (AEs)
- Ensure TPs are willing and able to provide services to all recipients, regardless of geographic location, health status, sex, age, race, ethnicity, color, sexual orientation, gender identity, national origin, religious affiliation, or need for transportation services; and promote a comprehensive transportation network that that does not permit adverse selection
- Enter into an agreement with the Rhode Island Public Transit Authority
- Ensure all transportation provider contracts are to be signed and executed. The broker must fully disclose all names of the brokers and provide evidence that all transportation needs will be met on the first day of the contract.
- Only contract with providers that are licensed and insured
- Have verified any issue regarding any subcontract being debarred and their process for background criminal checks of their employees
- Have a signed Business Associate Agreement with any sub broker who has access to PHI
- The Broker shall not subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440. 170.

The Broker shall maintain and make available all documentation for review by EOHHS staff on all contracts, including but not limited to each TP's business organizations, business licenses, certifications, insurance coverage, driver verifications, vehicle inspections, and all other relevant documentation, including payment rate structure upon request.

The Broker shall develop and implement a monitoring plan to monitor their contracted TPs to ensure compliance with the terms of their contracts. The HIPAA Privacy Rule requires that Broker obtain signed statement of HIPAA compliance from its TPs that will safeguard the protected health information they receive.

The Broker must maintain documentation for review by EOHHS staff on any TP's corrective action steps taken to ensure services provided are in compliance with this contract.

The Broker must ensure compliance with requirements of employer liability, worker's compensation, unemployment insurance, social security, and any other RI and local taxes applicable to the Broker and TPs.

The Broker must encourage Minority and Women-owned Business Enterprises (M/WBEs) to become TPs. providing transportation services to EOHHS's Broker.

The Broker is expressly prohibited from establishing or maintaining contracts with TPs which have been convicted of Medicaid or Medicare fraud, or have been terminated from the Medicare or Medicaid program, or have been excluded from participation in any Rhode Island DHS or EOHHS Program.

The Broker must terminate a service agreement with a TP when unacceptable performance, as determined by EOHHS, is identified or the TP has failed to take satisfactory corrective action within a reasonable time period not to exceed (30) thirty days from the date of notice of the unacceptable performance. Broker must execute a written agreement with TPs that specifies the Broker's right to revoke the agreement and outlines reasons for a revocation of the agreement. Broker shall indemnify and hold EOHHS harmless as against any claim for damages or losses arising from services rendered by TPs in connection with the performance of this contract. The Broker shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against then Broker or sub broker that, in the opinion of the Broker, may result in litigation related in any way to the Agreement with EOHHS.

Notification/Report to EOHHS

EOHHS must be notified within one (1) business day, of any additions or removals to the network. Any removals from the network must have a written plan submitted to EOHHS within 1 business day, of how transportation will be covered for the next 30 days or until another provider is found.

- The Broker will provide annual reports submitted to EOHHS by July 1 of each year that forecasts, monitors, and controls the overall costs of transportation service delivery by assigning trips to the lowest cost, most medically necessary mode available.
- Reports to EOHHS are also to include, Complaint Summary Report, Recipient Satisfaction Survey and Report, Performance Improvement Projects.
- Two Performance Improvement Projects and Recipient Satisfaction reports will be due by July 1 each year.
- Call statistics are to be submitted by the 15th of each month

- The Broker is to have mechanisms and systems that resolve access, quality, fraud and abuse, Broker management and payment issues.
- A Policy and Procedural Manual is to be developed and specific for the state of Rhode Island.
- A final version of the Policy and Procedural Manual must be submitted to the EOHHS for review and approval at least fifteen (15) days prior to the start of operations.
- Modifications required by the EOHHS must be incorporated by the Broker within ten (10) working days of notification.
- The Policy and Procedural Manual should include or reference specific separate attachments of policies on Program Integrity, Implementation Plan with Readiness Testing, Quality Assurance and Monitoring, Turnover Plan (to include resource turnover) and Communications Plan.
- The Broker shall be available to meet with the EOHHS representatives as indicated and at least monthly.

The Broker shall be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement; provided, however, that Broker agrees to indemnify and hold harmless the EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of Broker or its employees, acting alone or in collusion with others; and provided, further, that this maximum cap on damages shall not apply in the event that the loss arises in a situation in which Broker failed to follow its own policies and procedures. The maximum civil monetary penalty levied shall be in conformance with 42 CFR 438.704.

Operations

- The Broker shall not provide transportation directly.
- A routine pick up standard will be arriving no earlier than 15 minutes before scheduled trip nor later than 15 minutes after the scheduled pick-up time
- An urgent pick up standard will be within three (3) hours from when the Broker receives the request
- Pick up standard for a will call will be 60 minutes from when the Broker receives the request
- Drop-off standard will be on time but no more than 30 minutes early.
- The Broker will operate an efficient method for managing such services that requires recipients to request transportation with 48-hour advance notification (except for urgent or sick visits); Therefore, call Monday for transport Wednesday, call Tuesday for transport Thursday, Call Wednesday for transport Friday, Saturday

or Sunday, call Thursday for transport Monday, call for Friday for transport Tuesday

- The Broker shall ensure that all clients receive confirmation of their trip details by 6 pm the night before a schedule trip.

- The Broker shall maintain records and supporting data (including but not limited to recipient data, trip authorizations, claims data and provider records) in a retrieval and storage mechanism that complies with all Federal and State requirements;

- Ensure that records comply with State and Federal record retention requirements which are ten (10) years for medical records, source records and financial records and seven (7) years for litigation
- Medicaid transportation services delivered by the Broker are only reimbursable when the recipient is being transported to or from a Medicaid covered service delivered by a Medicaid provider.
- The Broker shall provide transportation services to all beneficiaries who request transportation services and:
  a) Are currently enrolled in Medicaid; and/or meets the criteria for the elderly transportation program (described in this Agreement and follow all sections of The Executive Office of Health and Human Services Regulations for Transportation.);
  a. Have a medical condition that prevents him/her from using fixed route bus services; and/or is requesting transportation to/from an origin/destination address that is more than 1/2 mile from a bus route.
- The Broker must verify recipient Medicaid eligibility by accessing daily the Rhode Island Medicaid Management Information System (MMIS) using the unique Medicaid identification number.
- The Broker must verify recipient eligibility regardless of who initiates the request.
- The Broker shall have policies and procedures submitted to EOHHS that provide transportation services on a non-discriminatory basis to eligible recipients irrespective of the regions, communities, or neighborhoods they live in or their age, race, religion, creed, national origin, sexual orientation, gender, ability, health status, or based on others with whom they live.

- The Broker's Policies and Procedures shall comply with all applicable state and federal laws pertaining to recipient rights, privacy and accommodation. The Broker shall require its employees and network providers to respect those rights when providing services to recipients.

TRANSPORTATION PROVIDER AND VEHICLE REQUIREMENTS

The Broker must maintain a detailed approach to ensuring all drivers and vehicles providing transportation services under this contract meet the minimum requirements listed in this Section. These requirements shall be included in all contracts with TPs. With prior approval from EOHHS, the Broker may establish additional, non-conflicting requirements for drivers and vehicles.

The Broker must commit to the following requirements in delivering its broker services:

- Ensure that all vehicles and drivers comply with the applicable laws, regulations, and ordinances of federal, state, and local agencies in the jurisdictions in which they operate, including public motor vehicle and taxicab authorities (RI PUC), and ambulance authorities (RI DOH).

- Ensure all contracted TP vehicles/drivers have operational AVL capabilities.

- Supply all contracted TPs with a copy of the Americans with Disabilities Act (ADA) vehicle requirements and inspect for compliance. Vehicles shall comply with the ADA Accessibility Specifications for Transportation vehicles, 49 CFR Part 38, Subparts A and B. Vehicles shall be in compliance with applicable ADA vehicle requirements in order to be approved for use under this program.

- Obtain and keep on file copies of required permits and licenses from the municipalities in which the contracted TP operates.

- Ensure that all contracted TPs maintain a physical address in Rhode Island, are registered with the Rhode Island Secretary of State and maintain sufficient liability insurance as required by Rhode Island law and regulations.

Though a Broker may establish additional qualifications, the Broker must ensure the following minimum qualifications are met by all contracted individuals responsible for driving recipients under the terms of this agreement. All drivers at all times during their employment shall be at least eighteen (18) years of age and have a current valid driver's license to operate the transportation vehicle to which they are assigned;

(a) Drivers shall not have a driver's license suspension or revocation for moving traffic violations within the previous five (5) years;

(b) A criminal background check on each contracted driver through the RI Bureau of Criminal Identification (BCI) or the National Crime Information Center (NCIC) if not a resident of Rhode Island for at least five (5) consecutive years), prior to employment and annually thereafter. For drivers not residing within the state of Rhode Island, criminal background checks equivalent to the BCI check from the driver's state of residence are also required;

(c) Drivers shall not have been convicted of any felony or misdemeanor related to health care fraud, patient abuse, child abuse, elderly abuse, criminal domestic violence, or criminal and/or sexual misconduct. A driver cannot be on any state or

federal Sex Offender Registry. Within the last ten (10) years, drivers shall not have been convicted of any other felony crime. Within the last ten (10) years, drivers shall not have been convicted of any misdemeanor crimes for theft, embezzlement, breach of fiduciary responsibility, other financial misconduct, domestic violence, assault and battery, drugs, or weapons;

(d) All drivers shall be courteous, patient, and helpful to all passengers and be neat and clean in appearance;

(e) No driver shall be under the influence of or use alcohol, narcotics, or illegal drugs while on duty. No driver shall use prescription or nonprescription medications or other substances that may impair the driver's ability to perform while on duty.

(f) All contracted TPs shall implement a verifiable 5-panel drug-testing program for drivers. Pre-employment, post-accident, and random drug screens covering more than twenty-five percent (25%) of the drivers each year shall be mandatory;

(g) All drivers shall wear and have a visible nametag, with picture, that is easily readable and identifies the employee and the employer. The driver shall show the nametag to the recipient or facility employee upon arrival to pick up the recipient;

(h) All contracted drivers must have their PUC identification visible during operation of their vehicle;

(i) Drivers are required to affix the EOHHS Transportation Broker sign to the side of the vehicle when in use for the transportation of recipients identified in the contract.

(j) Drivers shall not smoke (this includes e-cigarettes and non-combustible Tabaco product) or use tobacco of any kind while in the vehicle, while assisting a recipient or while in the presence of any recipient;

(k) Eating is prohibited in all vehicles while transporting recipients;

(l) Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones if this is the company communication device;

(m) Drivers shall not text or use a computer/tablet while driving;

(n) For door-to-door level of service drivers shall identify themselves, show their identification and announce their presence at the entrance of the facility or residence;

(o) Drivers shall assist recipients in the process of being seated and confirm that all seat belts are fastened properly;

(p) Drivers shall ensure recipients in wheelchairs are properly secured to the vehicle and/or wheelchairs are properly secured to vehicle prior to departure and at all times while in transit;

(q) Drivers shall ensure that children are secured in a child safety seat compliant with the RI Department of Public Safety Transportation guidelines for infant and child safety seats, as necessary; an adult escort is responsible for the car seat;

(r) US Department of Transportation-approved age-appropriate child restraint system (car/booster seat) prior to departure and at all times while in transit;

(s) Drivers shall provide necessary assistance, support, and verbal instructions to passengers. Such assistance shall include whatever is necessary for recipients with limited mobility as well as movement and storage of mobility aids and wheelchairs;

(t) Before departing the drop-off point, drivers shall confirm that the recipients are safely inside their destination;

(u) Drivers shall not touch any recipient except as appropriate and necessary to assist the recipient into or out of the vehicle, into a seat, to secure the seat belt, or to render first aid or assistance for which the driver has been trained;

(v) Drivers shall not solicit or accept money (except for co-pay requirements), goods or additional business from recipients;

(w) Drivers shall be familiar with the streets and highways of the areas in which they are transporting; and,

(x) Drivers shall follow company and Broker guidelines for HIPAA compliance by keeping all recipients' protected health information (PHI) confidential. It should not be visible to other recipients/passengers, and drivers shall not discuss this information with anyone who is not involved with the recipient's treatment or health care services.

Broker shall conduct all driver credential reviews prior to implementation, prior to the driver transporting recipients, and at least annually thereafter.

Ensure that all drivers complete and maintain the following EOHHS approved training and/or certification:

(a) Cardiopulmonary Resuscitation (CPR);
(b) First Aid;
(c) Defensive Driver;
(d) Passenger Assistance – transferring, loading, unloading;
(e) HIPAA Compliance; and
(f) Cultural competence training

(g) Participate in a minimum of twelve (12) hours in-service training on related subjects annually, including training on working with special populations such as disabled and/or elderly.

Ensure that the contracted TP terminates any driver from the transportation program when substandard performance is identified, as documented by the Broker or at the request of EOHHS. EOHHS reserves the right to direct the Broker to terminate any driver when EOHHS determines it to be in the best interest of the State.

The Broker must ensure all TP owners, drivers, and employees are not debarred, suspended, or otherwise excluded from participating in procurement activities under sections 1128(a)(1), 1932(d)(1) and 42 CFR 438.610 at the time of hire and thereafter. A searchable database of persons excluded can be found http://exclusions.oig.hhs.gov/.

Ensure all vehicles pass the Broker inspection prior to transporting recipients. Bidder shall provide criteria for inspection to EOHHS. The Broker shall inspect all vehicles transporting recipients annually and ensure all vehicles transporting recipients meet the following requirements:

(a) The TP shall provide and use a two-way voice communication system (mobile telephone or two-way radio) linking all vehicles used in delivering the services under this contract with the contracted TP's place of business. Pagers are not an acceptable substitute;

(b) All vehicles shall be equipped with adequate and functioning heating and air-conditioning systems. Functionality shall be defined by temperature readings from the rear of the vehicle, achieving air conditioning to sixty-eight (68) degrees and heating to seventy-two (72) degrees;

(c) All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position and securement belts for each wheelchair position; step stool should be available if needed.

(d) Each vehicle shall comply with all RI Department of Public Safety Transportation guidelines for infant and child safety seats, as necessary when transporting children; and adult escort if responsible for the car seat;

(e) Each vehicle shall have at least two (2) functional seat belt extensions available;

(f) Each vehicle shall be equipped with at least one (1) seat belt cutter within easy reach of the driver. Exceptions to this requirement shall be approved in advance by EOHHS;

(g) All vehicles shall have an accurate speedometer and odometer;

(h) All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment;

(i) The exterior of the vehicle shall be clean, free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicle;

(j) The interior of the vehicle shall be clean, free from torn upholstery, floor, or ceiling covering; free from damaged or broken seats; and free from protruding sharp edges. The interior shall also be free of dirt, oil, grease, and litter;

(k) Vehicles shall be free of hazardous debris or unsecured items and shall be operated within the manufacturer's safe operating standards at all times;

(l) To comply with HIPAA requirements, the word "Medicaid" may not be displayed on the vehicle or in the name of the business;

(m) The vehicle license number, the Broker's toll-free phone number and a local phone number for the Broker shall be prominently displayed on the interior of each vehicle. This information and the complaint procedures shall be clearly visible and available in written format in each vehicle for distribution to recipients upon request;

(n) All public motor vehicles (PMVs) used in the transportation network must have EOHHS-approved visible signage identifying the vehicle as part of the transportation system. All contracted drivers must have their PUC identification visible.

(o) All vehicles shall have the following signs in English and Spanish, posted in all vehicle interiors, easily visible to the passengers:
- "NO SMOKING (TOBACCO PRODUCTS or E-CIGS)"
- "ALL PASSENGERS MUST USE SEAT BELTS"

(p) Vehicles shall carry an information packet containing vehicle registration, insurance card, a copy of the form used for the latest Broker inspection, and accident procedures and forms;

(q) Vehicles shall be equipped with a first aid kit;

(r) Vehicles used for the transportation of recipients shall include GPS systems, which at a minimum, are capable of recalling the location of the vehicle for specific periods of time; and,

(s) Insurance coverage for all vehicles shall be in force at all times during the contract period in accordance with state and local regulations and contract requirements.

Broker must record and maintain a file of all vehicles inspected by the Broker and the file must be available upon request.

Broker must remove from service immediately any vehicle or driver found out of compliance with these contract requirements or any applicable state or federal regulations. Once the Broker verifies and documents that the deficiencies have been corrected, the vehicle or driver may be reinstated.

Any deficiencies and actions taken must be documented and become a part of the vehicle's and the driver's permanent records.

Ensure TPs comply with the following passenger safety requirements:

(a) Passengers shall have their seat belts buckled at all times while they are inside the vehicle. The driver shall assist passengers who are unable to fasten their own seat belts if requested;
(b) The driver shall not start the vehicle until all passenger seat belts have been buckled;
(c) The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity;
(d) Upon arrival at the destination, the vehicle shall be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination;
(e) Drivers shall not leave passengers unattended and
(f) If passenger behavior or other conditions impede the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic and notify their dispatcher or 911 to request assistance.

The Broker shall provide stretcher van service, ALS and BLS to Medicaid eligible recipients as an alternative mode of transportation for pre-authorized trips consistent with EOHHS policy. Stretcher service is provided to an individual who cannot be transported in an ambulatory or wheelchair van, and who does not need the medical services of an ambulance. Stretcher van service does not provide emergency medical transport and does not include any medical monitoring, medical aid, medical care, or medical treatment during transport. A driver and an assistant shall staff the vehicle, which is specifically designed and equipped to provide transportation of individuals on an approved stretcher. A stretcher van is used for an individual who:

(a) Needs routine transportation to or from a non-emergency medical appointment or service;
(b) Is convalescent or otherwise non-ambulatory and cannot use a wheelchair; and does not require medical monitoring, medical aid, medical care, or medical treatment during transport.

BUSINESS OFFICE AND CALL CENTER LOCATION

The Broker shall have non-residential administrative office ("central business office") that is reasonably accessible to the EOHHS Office (located in the Pastore Complex in Cranston, RI). The location and accessibility of the central business office will be considered as part of the technical evaluation. This office must be open to conduct the general administration functions of the Broker during normal business hours Monday through Friday, except on legal state holidays. The call center must be co-located with the Administrative Office.

All documentation must reflect the Broker's street address, local and toll-free telephone number. The General Manager of the contract must be located at the central business office.

The Broker must have the capacity to send and receive facsimiles at the central business office at

all times. The Broker's central office must be equipped with an adequate high-speed Internet connection. The Broker must provide a separate administrative telephone number that will enable EOHHS staff to reach the General Manager directly, without going through other office staff. The Broker must also have the capacity to reproduce documents upon request at no cost to EOHHS.

TRANSPORTATION RECIPIENT SERVICES

Call Center Staff Responsibilities

The Broker shall ensure that its Call Center staff and operators are capable of responding to telephone requests for information and that they respond to those requests in a timely manner. The Call Center staff and operators shall perform tasks including, but not limited to, the following:

A. Represent the Broker and EOHHS to the calling public;
B. Discuss the Program's main attributes courteously;
C. Provide prompt attention to the caller's needs;
D. Respect the caller's privacy during all communications and calls;
E. Maintain sensitivity to the diversity inherent in Rhode Island;
F. Maintain a professional demeanor at all times;
G. Assure the dissemination of accurate information to all callers;
H. Escalate calls from a dissatisfied recipient to a supervisor and on to a manager if satisfaction cannot be accomplished;
I. Document complaints or issues that are reported to the call center within the Call Center (i.e., late or missed pick up); and,
J. Transfer emergency transportation requests to 911 or another local emergency service.

Phone Lines and Equipment

The Broker shall supply a sufficient number of toll-free telephone lines to handle all calls 24 hours a day. For caller convenience and communication purposes a single toll-free telephone number must be used for the call center. The Broker must agree to relinquish ownership of the toll-free number to EOHHS upon contract termination.

Call flow routing and phone system queues must be reviewed by EOHHS. EOHHS may require additional queues with written notice to the Broker. The Broker shall obtain EOHHS approval prior to implementing any queue not required by EOHHS. The Broker shall provide a full description of the telephone system, including any specialized lines or routing to separately handle recipient and medical provider calls, as well as, an immediate trip problem resolution line.

Telephone Device for the Deaf (TDD)

The Broker shall maintain and operate a telephone device (TDD) for the deaf and hard of hearing callers who need such a device.

Automatic Call Distributor (ACD)

The Broker shall install and maintain a functioning Automatic Call Distributor (ACD) system and call reporting system that records and aggregates the following information, at a minimum, on an hourly, daily, weekly, and monthly basis, for the Call Center as a whole, and also for individual

operators:

A. Total number of incoming calls;
B. Number of answered calls by Broker staff;
C. Average Speed Answered;
D. Percentage of calls answered in thirty (30) seconds;
E. Average talk time;
F. Number of calls placed on hold and the length of time on hold;
G. Number of abandoned calls and length of time until call is abandoned;
H. Number of outbound calls; and,
I. Number of available operators by time.

The Call Center performance will be measured against key indicators that are considered to be standard for the call center industry.

Reporting on Phone Calls
The Broker must examine data collected from its phone system as requested by EOHHS and as necessary to perform quality assurance and improvement, fulfill the reporting and monitoring requirements of the Contract, and ensure adequate staffing.

Call Tracking Requirements

A. Identifying Information
The call center shall implement and maintain an automated call/contact management tracking system to track calls/contacts with basic identifying information.

B. Online Display
The call center shall allow inquiry and online display of call/contact records by type, original call/contact date, caller's name, caller ID number, customer service correspondent name or ID, or any combination of these data elements.

Extraction and Reporting
The Broker will create EOHHS-defined extract files that contain summary information on all calls/contacts received during a specified timeframe.

The Broker will generate other reports as required by EOHHS. Reports and data must be available in the format specified by EOHHS with export and import functions.

Back-Up System
In the event of power failure or natural disaster, the Broker shall have a back-up system capable of operating the telephone system at full capacity, with no interruption of services or data collection. The Broker shall notify EOHHS when its phone system is on a back-up system or is inoperative. The Broker shall have a manual back up procedure to allow requests to continue being processed if the system is down.

Call Center Performance Standards
The Broker shall perform the call center requirements to the standards in this Agreement, which will be evaluated by EOHHS.

The Broker shall develop a process to measure and correct any deficiencies in call center performance.

TRANSPORTATION PROVIDER SERVICES

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

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

- Eligibility and Benefits
- Prior Authorizations, referral requirements, care coordination and network questions
- Claims payment issues, appeal requests, complaints
- Assisting providers with questions concerning recipient eligibility status
- Assisting providers with Transportation prior authorization
- Assisting providers with claims payment procedures
- Handling provider complaints

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

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

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

Provider Manual

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

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

1. Description of the RI Medicaid Program and covered service
2. Medical necessity standards
3. Coordination of care expectations
4. Prior authorization and referral requirements
5. Recipients' rights and responsibilities
6. Reporting suspected fraud, waste, abuse
7. Payment policies
8. Important phone numbers
9. Broker's or Broker service standards (access and availability)
10. 24-hour coverage requirements
11. Complaints, Grievance and appeal procedures

PAYMENT

Acceptance of State Payments

Capitation Payments
Broker shall receive Capitation Payments for transportation recipients, as described in ATTACHMENT A, of this Agreement. All payments will be subject to the availability of funds and shall be subject to all condition specified in this Agreement. Adjustments to Capitation Payments due to recipient reconciliations will be as soon as possible, following their discovery. In addition, broker agrees to accept an 834 enrollment report, and subsequent enrollment and payment reports from the State. Broker is responsible for meeting performance metrics as outlined in the contract and RFP and is subject to liquidated damages as an offset to any payments made by the State including capitation payments as defined in the RFP.

Fee-For-Service Payments
The State shall reimburse Broker on a fee-for-service basis for covered services billed by Broker and not included within the pre-paid benefit package as described in this Agreement.

Payments to Sub brokers and Providers
The State shall bear no liability (other than liability for making payments required by this Agreement) for paying the valid claims of Broker sub brokers, including providers and suppliers.

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

due to (1) above, until written notice by EOHHS to the Broker.

- For Medicaid recipients
- For ETP recipients
- For TANF recipients

These rates shall be subject to annual review and revision by the EOHHS.

Liability for Payment
Broker agrees that recipients are not held liable as follows:

- Broker's debts, in the event of Broker's insolvency
- Covered services provided to the recipient, for which the State does not pay Broker, or the State, or Broker, does not pay the individual or the TP that furnishes the services under a contractual, referral, or other arrangement, or
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the recipient would owe if Broker provided the services directly

Liability during an Active Grievance or Appeal
Broker shall not be liable to pay claims to TPs if the validity of the claim is being challenged by Broker through a grievance or appeal, unless Broker is obligated to pay the claim or a portion of the claim through its contract with the TP.

Limit on Payment to Other Providers
No payment shall be made for services furnished by a TP other than Broker or by one of Broker's participating providers, if the services were available under the contract.

Actuarial Basis
The actuarial basis in the rate setting process for the computation of capitated rates is provided in ATTACHMENT C of this Agreement.

Claims Processing and MIS
Broker agrees to have claims processing system and Management Information System (MIS) sufficient to support the provider payment and data reporting requirements specified elsewhere in this contract. Broker also shall be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of recipients.

Audits
EOHHS, or its designees, maintains the right to conduct with reasonable notice whatever audit functions are necessary to verify proper invoicing by Broker for provision of services and proper payments by EOHHS to Broker in accordance with this contract.

In the event that audit liabilities arising from any discrepancies in payments are discovered during the course of such audits, the net effect of which resulted in an overpayment to Broker, EOHHS may either:

- Make a demand for repayment of overpayment amount within thirty (30) calendar days
- Offset the amount of overpayment from invoices submitted to provide for payment and/or by the next monthly payment cycle.
- Refer the matter to the Department of Attorney General Medicaid Fraud Unit for investigation and/or seek interest in funds pursuant to RI General Laws Section 40-8.2-22.

In the event that audits discover underpayment to Broker, EOHHS will process a corrective payment within thirty (30) calendar days.

Any dispute or controversy encountered pursuant to this provision shall be resolved pursuant to the guidelines specified herein.

Financial Data Reporting
Broker agrees to submit all financial report requests by the EOHHS. These reports may include, but are not limited to, the submission of the following reports:

- Broker's Annual Audited Financial Statements;
- Broker's Annual Report to Owners, Shareholders, recipients, and Others;
- Monthly Financial Statements;
- Company's General Liability and Directors' and Officer's Insurance Coverages;
- Where applicable, evidence that the parent Company provides 100% of subsidiary's financial backing.
- Any other additional reports required due to special circumstances, studies, analyses, audits, and significant changes in the Broker's financial position or performance.

Audit
In the case where the Agreement amount identified Section 2.13 (Payments) is at least twenty-five thousand dollars ($25,000) in any year, Broker must submit an acceptable audited financial statement prepared by an independent auditor within twelve (12) months of the end of the Broker's fiscal year. The audit must provide full and frank disclosure of all assets, liabilities, changes in fund balances, and all revenues and expenditures.

The State retains the right to conduct, or cause to be conducted, specific audits. These audits may be conducted upon reasonable notification to the Broker, and the audits would focus on matters related, but not limited, to:

- Invoicing by the Broker for provision of services;
- Payment to the Broker by the State;
- Compliance with any of the terms and conditions of the Contract or Contract

Amendments.

CONTRACT TERMS AND CONDITIONS

Contract Composition and Order of Precedence

Any submission made by Broker in response to the State's Request for Proposals shall be incorporated into this Agreement by reference. This Agreement shall be in conformity with, and shall be governed by, all applicable laws of the Federal government and the State of Rhode Island.

The component parts of the Agreement between the State of Rhode Island and Broker shall, in addition to the foregoing, consist of ADDENDUM I-XIX and:

ATTACHMENT A: Broker's Capitation Rates SFY 2019
ATTACHMENT B: Broker's Insurance Certificates
ATTACHMENT C: Rate-Setting Process
ATTACHMENT D: Performance Goals
ATTACHMENT E: Reporting Calendar

Integration Clause

This Agreement shall represent the entire agreement between the parties and will supersede all prior negotiations, representations, or agreements, either written or oral, between the parties relating to the subject matter hereof. This Agreement shall be independent of, and have no effect upon, any other contracts of either party, except as set forth to the contrary within.

Subsequent Conditions

Broker shall comply with all requirements of this Agreement and the State shall have no obligation to enroll any recipients into the Transportation Broker until such time as all of said requirements have been met.

Effective Date and Term

All terms and conditions stated herein are subject to final approval from CMS. This Agreement shall be effective from January 1, 2019 and shall be signed by Transportation Broker and the Rhode Island Executive Office of Health and Human Services and approved by CMS. The contract for three (3) years under the terms herein for the period January 1, 2019 to June 30, 2021 with three (3) one- year option periods, unless terminated prior to that date by provisions of this Agreement or extended by mutual agreement of the parties as provided for in this contract.

EOHHS may, at its discretion, defer the contractual operational start date for up to two (2) months beyond the scheduled start date of January 1, 2019 for a Broker that has been approved in the initial review process but that fails to satisfy all readiness review requirements.

Contract Administration

This Agreement shall be administered for the State by the Rhode Island Executive Office of Health and Human Services (EOHHS). The Medicaid Director or their appointee will serve as the

responsible party for all matters related to this Agreement.

The Administrator, or his or her designee, shall be Broker's primary liaison in working with other State staff and with the State's private program management broker. In no instance shall Broker refer any matter to Medicaid Director or any other official in Rhode Island unless initial contact, both verbal and in writing, regarding the matter has been presented to the Administrator or designee.

Whenever the State is required by the terms of this Agreement to provide written notice to Broker, such notice shall be signed by the EOHHS Administrator or designee, or, in that individual's absence or inability to act, such notice shall be signed by Medicaid Director. All notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in this article shall be issued by the EOHHS Administrator or designee.

Contract Officers
EOHHS will designate a Contract Officer. Such designation may be changed during the period of this Agreement only by written notice. A representative of the Broker's choice shall be authorized and empowered to represent Broker with respect to all matters within such area of authority related to implementation of this Agreement.

Liaisons
Broker shall designate an employee of its administrative staff and EOHHS hereby designates its Contract Officer, who shall act as liaisons, between Broker and EOHHS for the duration of the Agreement. The Contract Officer shall receive all inquiries regarding this Agreement and all required reports. Broker also shall designate a recipient of its senior management who shall act as a liaison between Broker's senior management and EOHHS when such communication is required.

Notification of Administrative Changes
Broker shall notify EOHHS of all changes materially affecting the delivery of care or the administration of its program. An example of such a material change would be a change which could affect Broker's ability to meet performance standards.

Notices
Any notice under this Agreement required to be given by one party to the other party, shall be in writing and given by certified mail, return receipt requested postage pre-paid or overnight carrier which requires a receipt, of delivery in hand with a signed for receipt, and shall be deemed given upon receipt.

Notices shall be addressed as follows:

> In case of notice to Broker: Chief Executive Officer
>
> In case of notice to EOHHS: EOHHS Administrator, 3 West Road, Virks Building, Cranston, RI 02920

Either party may change its address for notification purposes by mailing a notice stating the change

and setting forth the new address.

Authority
Each party has full power and authority to enter into and perform this Agreement, except to the extent noted in Section 2.19 below, and by signing this Agreement, each party certifies that the person signing on its behalf has been properly authorized and empowered to enter into this Agreement. Each party further acknowledges that it has read this contract, understands it, and agrees to be bound by it.

Federal Approval of Contract
CMS has final authority to approve all contracts between states and brokers in which payment exceeds one-hundred thousand dollars ($100,000.00). If CMS does not approve a contract entered into under the Terms & Conditions described herein, the Agreement will be considered null and void.

INTERPRETATIONS AND DISPUTES

Conformance with State and Federal Regulations
Broker agrees to comply with all State and Federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including those not specifically mentioned in this article. In the event that Broker may, from time to time, request the State to make policy determinations or to issue operating guidelines required for proper performance of this Agreement, the State shall do so in a timely manner, and Broker shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and shall incur no liability in doing so unless Broker acts negligently, maliciously, fraudulently, or in bad faith.

Waivers
No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Agreement shall be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings.

Waiver of any breach of any term or condition in this Agreement shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Agreement shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

Severability
If any provision of this Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and Broker shall be relieved of all obligations arising under such provision; if the remainder of this Agreement is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

To this end, the terms and conditions defined in this Agreement can be declared severable.

Jurisdiction
This Agreement shall be governed in all respects by the Laws and Regulation of the State of Rhode Island. Broker agrees to submit to the jurisdiction of the State of Rhode Island should any dispute, disagreement or any controversy of any kind arise or result out of the terms, conditions or interpretation of this Agreement. Broker, by signing this Agreement, agrees and submits to the jurisdiction of the courts of the State of Rhode Island and agrees that venue for any legal proceeding against the State regarding this Agreement shall be filed in the Superior Court of Providence County.

Disputes
Prior to the institution of arbitration or litigation concerning any dispute arising under this Agreement, the Chief Purchasing Officer of the State of Rhode Island is authorized, subject to any limitations or conditions imposed by regulations, to settle, compromise, pay, or otherwise adjust the dispute by or against or in controversy with, a Broker relating to a contract entered into by the Department of Administration on behalf of the State or any State agency, including a claim or controversy based on contract, mistake, misrepresentation, or other cause for contract modification or rescission, but excluding any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official other than the Chief Purchasing Officer is specifically authorized to settle or determine such controversy.

A "contract dispute" shall mean a circumstance whereby a Broker and the State user agency are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of a contract.

The Chief Purchasing Officer shall be authorized to resolve contract disputes between Brokers and user agencies upon the submission of a request in writing from either party, which request shall provide:

- A description of the problem, including all applicable citations and references from the contract in question.
- A clear statement by the party requesting the decision of the Chief Purchasing Officer's interpretation of the contract.
- A proposed course of action to resolve the dispute.

The Chief Purchasing Officer shall determine whether:

- The interpretation provided is suitable.
- The proposed solution is feasible.
- Another solution may be negotiable.

If a dispute or controversy is not resolved by mutual agreement, the Chief Purchasing Officer or his designee shall promptly issue a decision in writing after receipt of a request for dispute resolution. A copy of the decision shall be mailed or otherwise furnished to Broker. If the Chief Purchasing Officer does not issue a written decision within thirty (30) days after written request for a final decision, or within such longer period as might be established by the parties to the contract in writing, then Broker may proceed as if an adverse decision had been received.

In the event an adverse decision is rendered, Broker may proceed to Superior Court and commence litigation against the State. If damages awarded on any contract claim under this section exceed the original amount of the contract, such excess shall be limited to an amount which is equal to the amount of the original contract. No person, firm, or corporation shall be permitted more than one (1) money recovery upon a claim for the enforcement of or for breach of contract with the State.

In no event, shall the terms of this section apply to disputes between providers and Broker nor shall the State be entitled to arbitrate such disputes.

Any fraudulent activity may result in criminal prosecution.

CONTRACT AMENDMENTS

General

The Executive Office may permit changes in the scope of services, time of performance, or approved budget of the Broker to be performed hereunder. Such changes, which are mutually agreed upon by the Executive Office and the Broker, must be in writing and shall be made a part of this agreement by numerically consecutive amendment excluding "Special Projects", if applicable, and are incorporated by reference into this Agreement.

Special Projects are defined as additional services available to the Executive Office on a time and materials basis with the amounts not to exceed the amounts referenced to in this agreement or as negotiated by project or activity. The change order will specify the scope of the change and the expected completion date. Any change order shall be subject to the same terms and conditions of this Agreement unless otherwise specified in the change order and agreed upon by the parties. The parties will negotiate in good faith and in a timely manner all aspects of the proposed change order.

An approved contract amendment is required whenever a change affects the payment provisions, the scope of work, or the length of this Agreement. Formal contract amendments will be negotiated by the State with Broker whenever necessary to address changes to the terms and conditions, the costs of, or the scope of work included under this Agreement. An approved contract amendment means one approved by EOHHS, Broker, and all other applicable State and Federal agencies prior to the effective date of such change.

An approved contract amendment shall be in writing and shall be signed by EOHHS, Broker and all other applicable State and Federal agencies prior to the effective date of the Amendment.

The Broker agrees to provide a signed amendment no later than 45 calendar days after being provided the final Amendment by EOHHS. Failure to return a signed Amendment within 45 calendar days or to negotiate a new due date with EOHHS may result in, but not be limited to, a hold placed on the approval of recipient materials or suspension of service provision, to be in place until return of an executed copy of the Amendment.

The State and Broker shall use contract amendments to reduce or increase Payments caused either through changes in the scope of benefits as a result of changes in Federal or State law or regulations or any other reason, scope of benefits otherwise covered by the State, the beneficiaries covered by this Agreement, and/or extension of the term of this Agreement. Annual adjustments in capitation payments shall be made in conformance with actuarial soundness, for any applicable period of time, taking into account the budget neutrality limitations placed on Rhode Island Medicaid by CMS.

GUARANTEES, WARRANTIES, AND CERTIFICATIONS

Broker Certification of Truthfulness

By signing this Agreement, Broker certifies, under penalty of law, that the information provided herein is true, correct, and complete to the best of Broker's knowledge and belief. Broker acknowledges that should investigation at any time disclose any misrepresentation or falsification, this Agreement may be terminated by EOHHS upon written notice specifying the misrepresentation or falsification without penalty of further obligation by EOHHS.

Broker Certification of Legality

Broker represents, to the best of its knowledge, that it has complied with and is complying with all applicable statutes, orders, and regulation promulgated by any Federal, State, municipal, or other governmental authority relating to its property and the conduct of operations; and, to the best of its knowledge, there are no violations of any statute, order, rule, or regulation existing or threatened.

Performance Bond or Substitutes

Broker shall furnish a performance bond, a cash deposit, or an irrevocable letter of credit. The performance bond shall be in a form acceptable to the State. If a cash deposit is used, it should be placed in different financial institutions to a maximum of one-hundred thousand dollars ($100,000.00) per deposit. If a letter of credit is used, the letter should be issued by a bank doing business in the State of Rhode Island and insured by the Federal Deposit Insurance Corporation; a savings and loan institution doing business in the State of Rhode Island and insured by the Federal Savings and Loan Insurance Corporation; or a credit union doing business in the State of Rhode Island and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit, or letter of credit shall be a minimum of one dollar for each capitation dollar paid in the month, or as determined by the EOHHS Administrator or designee. The State shall evaluate the enrollment statistics of Broker on a monthly basis. If there is an increase in the total capitation payment that exceeds 10 percent (10) above the

previous month's total Capitation Payment, the State may require a commensurate increase in the amount of the performance bond, cash deposit, or letter of credit. Broker shall have ten (10) business days to comply with any such increase.

The State may, at its discretion, permit Broker to offer substitute security in lieu of a performance, bond, cash deposit, or letter of credit. In that event, Broker shall be solely responsible for establishing the credit worthiness of all forms of substitute security. Broker also shall agree that the State may, after supplying written notice, withdraw its permission for substitute security, in which case Broker shall provide the State with a form of security as described above. In the event of termination for default, the performance bond, cash deposit, letter of credit or substitute shall become payable to the State for any outstanding damage assessments against Broker. Up to the full amount of the performance bond or substitute may also be applied to Broker's liability for any administrative costs and/or excess medical or other costs incurred by EOHHS in obtaining similar services to replace those terminated as a result of the default. The State may seek other remedies under law or equity in addition to this stated liability.

Subcontracts

Broker may enter into written subcontract(s) for performance of certain of its contract responsibilities. All subcontracts must be in writing and fulfill the requirements related to the service or activity delegated under this Agreement. Broker shall make available all subcontracts for inspection by the State, upon request.

The HIPAA Privacy Rule requires that a covered entity obtain satisfactory assurances from its subcontracted and delegated entities that they will safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other business associate agreement between the covered entity and the business associate.

Broker shall be wholly responsible for performance of the entire contract whether or not sub brokers are used. The Broker must execute a written agreement with its sub brokers that specifies that Broker's right to revoke the subcontract, and outlines reasons for the revocation of the contract. Broker must also execute a written agreement which states that Broker may impose sanction on the sub broker if the sub broker's performance is inadequate. Any subcontract which Broker enters into with respect to performance under this Agreement shall not relieve Broker in any way of responsibility for performance of its duties. Further, the State will consider Broker to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Agreement.

Broker shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against Broker or sub broker that, in the opinion of Broker, may result in litigation related in any way to the Agreement with EOHHS.

Executive Order 92-4 encourages each State agency to meet a goal of ten percent (10%) of the dollar value of all procurement be awarded to small and small disadvantaged and minority and woman-owned businesses as sub brokers, pursuant to the provisions of Part 19 of Title 48, Federal Acquisition Regulations; and ATTACHMENT A: Capitation Rates.

Broker agrees, and shall require its sub brokers to agree, to subrogate to EOHHS any and all

claims the Broker has or may have against any provider, including but not limited to manufacturers, wholesale or retail suppliers, sales representatives, or other providers in the design, manufacture, marketing pricing, or other products, in actions brought against said Providers, etc., on behalf of EOHHS, through the Rhode Island Attorney General's Office. Broker is entitled to recoveries that are the direct result of a similar legal suit filed by Broker against the same party or parties that was initiated and properly filed prior to the date of a legal action initiated or joined by EOHHS or by the Rhode Island Department of Attorney General.

Broker agrees to inform providers and sub brokers, at the time they enter into a contract, about:

1. Recipient's right to a state fair hearing,
2. How a recipient can obtain a hearing,
3. Representation rules at a hearing
4. Right to file a grievance and appeal and,
5. The requirements and timeframe for filing a grievance and appeal
6. Right to request continuation of service during an appeal or State Fair Hearing filing but that the recipient may be responsible for the cost of any continued benefit if the original action is upheld.
7. The toll-free number to file oral grievances and appeals.
8. State-determined transportation provider's appeals rights to challenge the failure of an organization to reimburse a service.

All of the program standards described in this agreement shall apply to sub brokers, to the extent relevant, to the duties they are performing.

Assignment of the Contract

Broker shall not sell, transfer, assign, or otherwise dispose of this Agreement or any portion thereof or of any right, title, or interest therein without the prior written consent of the State. Such consent, if granted, shall not relieve Broker of its responsibilities under this Agreement. This provision includes reassignment of this Agreement due to change in ownership of the firm. State consent shall not be unreasonably withheld.

Hold Harmless

Broker agrees to defend (subject to the approval of the Attorney General), indemnify, and hold harmless the State of Rhode Island, its Executive Offices, agencies, branches and its or their officers, directors, agents or employees (together the "Indemnities" and their sub brokers) against any claim, loss, damage, or liability incurred as a result of any breach of the obligations of this agreement by Broker or any sub broker including:

- Any claims for damages or losses arising from services rendered by any sub broker, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the contract.

- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by Broker, its officers, employees, or sub brokers in the

performance of the contract.

- Any claims for damages or losses resulting to any person or firm injured or damaged by Broker, its officers, employees, or sub brokers by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the contract in a manner not authorized by the contract or by Federal or State regulations or statutes.

- Any failure of Broker, its officers, employees, or sub brokers to observe the Federal or State laws, including, but not limited to, labor laws and minimum wage laws.

- Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

Before delivering services under this Agreement, Broker shall provide adequate demonstration to the State that insurance protections necessary to address each of these risk areas are in place.

Broker may elect to self-insure any portion of the risk assumed under the provision of this Agreement based upon Broker's ability (size and financial reserves included) to survive a series of adverse financial actions, including withholding of payment or imposition of damages by the State.

Insurance
Before delivering services under this Agreement, Broker shall obtain, from an insurance company duly authorized to do business in Rhode Island, the minimum coverage levels described below for:

- Professional liability insurance
- Workers' compensation
- Comprehensive liability insurance
- Property damage insurance
- Errors and Omissions insurance
- Reinsurance

ATTACHMENT B of this Agreement contains Broker's Certificates of Insurance. Each certificate states the policy, the insured, and the insurance period. Each of the Broker's insurance policies shall contain a clause, which requires the State be notified ten (10) days prior to cancellation.

Broker shall be in compliance with all applicable insurance laws of the State of Rhode Island and of the Federal Government throughout the duration of this Agreement.

Professional Liability Insurance
Broker shall obtain and maintain, for the duration of this Agreement, professional liability insurance in the amount of at least one-million dollars ($1,000,000.00) for each occurrence.

Workers' Compensation
Broker shall obtain and maintain, for the duration of this Agreement, workers' compensation insurance for all of its employees employed in Rhode Island. In the event any work is subcontracted, Broker shall require the sub broker similarly to provide workers' compensation insurance for all the latter's employees employed at any site in Rhode Island, unless such sub broker's employees are covered by the workers' compensation protection afforded by the Broker. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State of Rhode Island.

Minimum Liability and Property Damage Insurance
Broker shall obtain, pay for, and keep in force general liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of one-million dollars ($1,000,000.00) for any one (1) occurrence; and insurance against liability for property damages, as well as first-party fire insurance, including contents coverage for all records maintained pursuant to this Agreement, in the amount of five-hundred thousand dollars ($500,000.00) for each occurrence; and such insurance coverage that will protect the State against liability from other types of damages, for up to five-hundred thousand dollars ($500,000.00) for each occurrence.

Errors and Omissions Insurance
Broker shall obtain, pay for, and keep in force for the duration of the contract Errors and Omissions insurance in the amount of one-million dollars ($1,000,000.00).

Reinsurance
Broker shall obtain, pay for, and keep in force reinsurance for the reimbursement of excess costs incurred by a recipient. The level at which the Broker establishes reinsurance must be consistent with sound business practices under the financial condition of the Broker. Broker may not change the thresholds from those submitted in response to the bid solicitation and incorporated into ATTACHMENT B of this Agreement without the prior written consent of the State.

Evidence of Coverage
Broker shall furnish to the State upon request a certificate(s) evidencing that required insurance is in effect, for what amounts, and applicable policy numbers and expiration dates prior to start of work under the Agreement. In the event of cancellation of any insurance coverage, Broker shall immediately notify the State of such cancellation. Broker shall provide the State with written notice at least ten (10) days prior to any change in the insurance required under this subsection.

Broker shall also require that each of its sub brokers maintain insurance coverage as specified above or provide coverage for each sub broker's liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of Broker or any of its sub brokers hereunder.

Force Majeure

Neither Broker nor the State shall be liable for any damages or excess costs for failure to perform their contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by Broker or the State. Such causes may include, but are not restricted to, fires, earthquakes, tornadoes, floods, unusually severe weather, or other catastrophic natural events or acts of God: quarantine restrictions; explosions; subsequent legislation by the State of Rhode Island or the Federal government; strikes other than Broker's employees; and freight embargoes. In all cases, the failure to perform must be beyond reasonable control of, and without fault or negligence of, either party.

Patent or Copyright Infringement
Broker shall represent that, to the best of its knowledge, none of the software to be used, developed, or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from Broker's use of any equipment, materials, computer software and products, or information prepared by or on behalf of Broker, or developed in connection with Broker's performance of this Agreement, then Broker shall, at its expense, defend such claim or suit. Broker shall satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with Broker's right of approval.

Payments to Institutions or Entities Located Outside of the U.S.
The Broker must be located within the U.S. The Broker will make no payments to a TP, sub broker or financial institution located outside of the U.S. Broker will issue no payments for items or services to providers, provider bank accounts or business agents located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

PERSONNEL

Employment Practices
Broker shall agree to comply with the requirements relating to fair employment practices, to the extent applicable and agrees further to include a similar provision in any and all subcontracts. Broker shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Broker shall take affirmative action to ensure that employees, as well as applicants for employment, are treated without regard to their race, color, religion, sex, national origin, age (except as provided by law), marital status, political affiliation, or handicap. Such action shall be taken in areas including, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

Broker shall agree to post in a conspicuous place, available to employees and applicants for employment, notices setting forth the provision of this non-discrimination clause. Broker shall, in all solicitations or advertisements for employees placed by or on behalf of Broker, state that all qualified applicants will receive consideration for employment without regard to race, color,

religion, sex, national origin, sexual orientation, age (except as provided by law), marital status, political affiliation, or handicap, except where it relates to bona fide occupational qualification. Broker shall send to each labor union or representative of workers with which he has a collective bargaining arrangement or other agreement or understanding, a notice advising the labor union or workers' representative of Broker's commitments under Section 202 of Executive Order No. 11246 of September 24, 1976, as amended, and the rules, regulations, and relevant orders of the Secretary of Labor.

Broker shall agree to comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 USC 2000D et seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794); Title IX of the Education Amendments of 1972 (20 USC 1681 et seq.); Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.); The Food Stamp Act, and the Age Discrimination Act of 1975; the United States Department of Health and Human Services regulations found in 45 CFR, parts 80 and 84; the United States Department of Education implementing regulations (34 CFR, parts 104 and 106) which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities; and the United States Department of Agriculture, Food and Nutrition Services (7 CFR 272.6), which prohibit discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, political beliefs, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities, or as any of the Acts are amended from time to time.

Broker shall comply with all provisions of Executive Order No. 11246 of September 24, 1976, as amended, and of the rules, regulations, and relevant orders of the Secretary of Labor. Broker shall furnish all information and reports required by Executive Order No. 11246 of September 24, 1976, as amended, and by the rules, regulations, and orders of the Secretary of Labor or pursuant thereto and will permit access to its books, records, and accounts by the Secretary of the U.S. Department of Health and Human Services and the U.S. Secretary of Labor or their authorized representatives for purposes of investigation to ascertain compliance with rules, regulations, and orders.

Broker shall comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Orders 11625 and 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. Broker shall comply with regulations issued by the Secretary of Labor of the United States in Title 20, Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758 and the Federal Rehabilitation Act of 1973. Broker shall be responsible for ensuring that all sub brokers comply with the above-mentioned regulations. Broker and its sub brokers shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Vocational Rehabilitation Act of 1973, as amended.

Broker shall comply with all applicable provisions of Stat. 53-1147, the Federal "Hatch Act," as amended.

Broker shall comply with all applicable provisions of Public Law 101-336, Americans with

Disabilities Act.

Pursuant to Title VI and Section 504, as listed above which are incorporated herein by reference and made part of this Agreement, the Broker shall have policies and procedures in effect, including, mandatory written compliance plans, which are designed to assure compliance with Title VI section 504, as referenced above. An electronic copy of the Broker's written compliance plan, all relevant policies, procedures, workflows, relevant chart of responsible personnel, and/or self-assessments must be available to EOHHS upon request.

The Broker's written compliance plans and/or self-assessments, referenced above and detailed in this Agreement must include but are not limited to the requirements detailed in this Agreement.

The Broker must submit, within thirty-five (35) days of the date of a request by DHHS or EOHHS, full and complete information on Title VI and/or Section 504 compliance and/or self-assessments, as referenced above, by the Broker and/or any sub broker or broker of the Broker.

The Broker acknowledges receipt of ADDENDUM II - Notice to Executive Office of Health and Human Services' service providers of their responsibilities under TITLE VI of the civil rights act of 1964 and ADDENDUM VI - Notice to executive office of health and human services' service providers of their responsibilities under section 504 of the Rehabilitation Act of 1973, which are incorporated herein by reference and made part of this Agreement.

The Broker further agrees to comply with all other provisions applicable to law, including the Americans with Disabilities Act of 1990; the Governor's Executive Order No. 05-01, Promotion of Equal Opportunity and the Prevention of Sexual Harassment in State Government.

The Broker also agrees to comply with the requirements of the Executive Office of Health and Human Services for safeguarding of client information as such requirements are made known to the Broker at the time of this contract. Changes to any of the requirements contained herein shall constitute a change and be handled in accordance with the Contract Amendments noted in Section 3.03.

Failure to comply with this Paragraph may be the basis for cancellation of this Agreement. Broker shall agree to comply with all other State and Federal statutes and regulations that are or may be applicable and that are not specifically mentioned above.

Employment of State Personnel

Broker shall not knowingly engage on a full-time, part-time, or other basis, during the period of this Agreement, any professional or technical personnel who are, or have been at any time during the period of this Agreement, State employees, except those regularly retired individuals, without prior written approval from the EOHHS Administrator or designee. Such approval shall not be unreasonably withheld.

The penalty for violation of the above conditions shall result in two thousand five hundred dollars ($2,500.00) penalty per employee, plus an added two thousand five hundred ($2,500.00) penalty per month, per employee if Broker or sub broker fails to terminate the employee after they have been notified in writing of the violation by the State's designated contract administrator.

Independent Capacity of Broker Personnel
It is expressly agreed that Broker or any sub broker involved in the performance of this Agreement shall act in an independent capacity and not as an agent, officer, employee, partner, or associate of the State of Rhode Island. Broker staff will not hold themselves out as nor claim to be officers or employees of the State of Rhode Island by reason hereto. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between Broker or any sub broker and the State.

RECORDS RETENTION

Broker agrees to maintain books and records relating to transportation services and expenditures covered under this Agreement, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements and records relating to quality of care.

Operational Data Reports
Broker agrees to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information. Financial records must be retained for at least ten (10) years.

PERFORMANCE STANDARDS AND DAMAGES

OPERATIONAL DATA REPORTING

The broker shall comply with all of the reporting requirements established by EOHHS. EOHHS shall provide the Contactor with the necessary reporting formats, instructions, submission timetables and technical assistance, as required. EOHHS may at its discretion, change the content, format or frequency of reports. If the Broker delegate's responsibility to a sub broker, the Broker shall ensure the subcontracting relationship and subcontracting documentation comply with EOHHS reporting requirements.

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

The Broker will submit all reports to EOHHS, unless otherwise indicated in this contract according to the schedule below:

Deliverables		Due Date
Daily Reports		Within two (2) business days
Weekly Reports		Wednesday of the following week
Bi-Weekly Reports		5th and 20th of each month

Monthly Reports		Last business day of the following month
Quarterly Reports		Last business day of the month following the end of the quarter
Semi-annual Reports		January 31 and July 31
Annual Reports		As specified by the State
Ad Hoc/On Demand		As specified by the State

The Broker will submit all reports electronically and in the manner and format prescribed by EOHHS and shall ensure that all reports are complete and accurate. Broker will submit reports to EOHHS and other State agencies or delegates as indicated. Except as otherwise specified by EOHHS, all reports shall include all transportation populations governed by this contract.

The Contactor shall transmit to and receive from EOHHS, all transactions and code sets in the required standard formats as specified under HIPAA and as directed by EOHHS, so long as EOHHS direction does not conflict with the law.

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

Broker agrees to provide EOHHS with uniform utilization, quality assurance, and Recipient satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to EOHHS.

Timeliness and Accuracy of Data Submittal
The Broker is responsible for monitoring their 837 submissions and subsequent 277CA reports. The Broker shall submit encounter data to the State monthly, at a minimum.

Penalties for Non-Compliance
At the discretion of EOHHS, Broker may be subject to penalties for continued non-compliance with timely, accurate and resolved submission of data or aggregate reporting requirements.

Grievance and Appeals Data
Broker agrees to submit reports in the required format and timetables identified by EOHHS. Broker agrees to submit quarterly reporting for Complaints, Grievance and Appeals submitted to the Broker. Reports will be inclusive of all recipient populations in this contract. This report is due no later than thirty (30) days after the end of the reporting quarter.

EOHHS Quality Assurance Data
Broker agrees to make available internal quality assurance reports periodically to EOHHS, as EOHHS may specify. The precise methodology for these abstracts will be provided to the Broker by EOHHS. Broker agrees to work cooperatively with EOHHS in developing and implementing this methodology.

Recipient Satisfaction Report
Broker agrees to collect Recipient satisfaction data for all recipient populations through an annual survey of a representative sample of its recipients.

Fraud and Abuse Reports
Broker agrees to submit a quarterly fraud and abuse report that conforms to EOHHS's specifications. This report is due no later than thirty (30) days after the end of the reporting quarter.

The report shall indicate at minimum: (1) the number of complaints of fraud and abuse that warranted preliminary investigation, and (2) for each case of suspected provider fraud and abuse that warrants a full investigation. For the latter case, the broker shall report the following:

- the transportation provider's name and number
- the source of the complaint
- the nature of the complaint
- the approximate range of dollars involved
- the legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.

Recovery Reporting
Broker must establish a mechanism for a TP to report to the Broker when it has received an overpayment, to return the overpayment to the Broker within 60 calendar days after the date on which the overpayment was identified, and to notify the Broker in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities.

Presentation of Findings
Broker agrees to obtain EOHHS's approval prior to publishing or making formal public presentations of statistical or analytical material based on its Recipient enrollment.

Health Insurance Portability and Accountability Act Requirements (HIPPA)
Broker will comply with the operational and information system requirements of HIPAA and will report requested data to EOHHS.

Certification of Data
Broker agrees to certify all data submitted. The certification must attest, based on best knowledge, information, and belief, as follows:

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

Broker must submit the certification concurrently with the certified data.

Utilization Review and Quality Assurance (UR/QA)
Broker shall have written policies and procedures to monitor utilization of services by its recipients and to assure the quality and accessibility of care being provided in its network.

Utilization Review
Broker shall have written utilization review policies and procedures that include protocols for denial of services, prior approval, and retrospective review of claims. As part of its utilization review function, Broker also agrees to have processes to identify utilization problems and undertake corrective action. As part of this function, Broker shall have a structured process for the approval or denial of covered services. This shall include, in the instance of denials, formal written notification to the recipient and the requesting or treating provider of the denial, its basis and any applicable appeal rights and procedures including EOHHS/Department-level appeal within fourteen (14) days of the request for authorization. Broker shall demonstrate to EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.
The Broker shall define service authorization in a manner that at least includes a recipient's request for the provision of services as described in this Agreement.

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

- Written notice must be translated for individuals who speak prevalent non-English languages, as defined in this Agreement.

- Notice must include language clarifying that oral interpretation is available for all languages and how to access it.

- Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration for those with special needs.

- Recipients and potential recipients must be informed that information is available in alternative formats and how to access those formats.

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

Confidentiality
Broker must have written policies and procedures for maintaining the confidentiality of data that conform to HIPAA requirements.

State and Federal Reviews
Broker agrees to make available to EOHHS, on as needed basis, any records for review of quality of care and access issues. Broker agrees to make available to CMS and/or EOHHS any records for review as requested.

Fraud and Abuse
The Broker shall establish and maintain internal controls which are designed and executed to prevent, detect, investigate, and report suspected Medicaid Fraud and Abuse that may be committed by network providers, non-network providers, brokers, sub brokers, employees, recipients, or other third parties with whom the Broker contracts. The Broker shall comply with all Federal and State requirements regarding Medicaid fraud and abuse, including but not limited to Sections 1124, 1126(b)(1), 1126(b)(2), 1126(b)(3), 1128, 1156, 1892, 1902(a)(68), and 1903(i)(2) of the Social Security Act and Section 40-8.2- 2 of the General Laws of Rhode Island. EOHHS and its Office of Program Integrity may conduct audits at any time on the Broker's formal fraud, waste and abuse program as well as any files as a result of claims audits.

The Broker will cooperate fully with any investigations, including providing information, access to records, and access to interview Broker employees and consultants at the time determined by the State. Provider contracts with the Broker shall incorporate these terms and conditions.

The following terms (abuse, conviction or convicted, exclusion, fraud, furnished, practitioner, and suspension) shall have the meaning specified in 42 CFR 455.2:

- Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

- Conviction or convicted means that a judgment of conviction has been entered by a Federal, State, or local court; regardless of whether an appeal from that judgment is pending

- Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

- Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

- Furnished refers to items and services provided directly by, or under the direct supervision

of, or ordered by, the broker, a TP, or other supplier of services.

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

An electronic copy of the Broker's written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse must be submitted to the Rhode Island EOHHS for review and approval within 90 days of the execution of this Agreement and then on an annual basis thereafter.

Mandatory Components of Employee Education about False Claims Recovery
In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Broker receives more than five million dollars ($5,000,000) in Medicaid payments on an annual basis, then it must establish and disseminate written policies for all employees, including management and any sub broker or agent of the Broker, that include detailed information about the False Claims Act, established under sections 3279 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil and criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act).

Section 6032 of the Deficit Reduction Act establishes section 1902(a)(68) of the Social Security Act, which relates to "Employee Education about False Claims Recovery". The Broker's written policies pertaining to employee education about false claims recovery may be on paper or in electronic form but must be readily available to all of the Broker's employees, brokers, or agents. The Broker's policies and procedures must include detailed information about the prevention and detection of Medicaid waste, fraud, and abuse.

The Broker shall also include in any employee handbook a specific discussion of the laws described in the written policies and the rights of employees to be protected as whistleblowers. The employee handbook must also include a specific discussion of the Broker's policies and procedures for preventing and detecting fraud, waste, and abuse.

Recipient Education about Medicaid Fraud and Abuse
The Broker shall educate its recipients about Medicaid fraud and abuse by including this subject matter in the broker's recipient handbook. This content shall address examples of possible Medicaid fraud and abuse by providers or brokers, as well by recipient, and must be pre-approved by EOHHS.

In its recipient handbook, the Broker shall also inform recipients about how to report suspected Medicaid fraud and abuse, including any dedicated toll-free telephone number established by the Broker for reporting possible Medicaid fraud and abuse, as well as information about how to contact EOHHS's Fraud Unit.

Recipient Verification Procedures
The Broker shall be responsible for establishing procedures to verify with recipients, whether services billed by providers and brokers occurred.

The Broker will document its recipient verification procedures and include these materials in its submission of written operating policies, procedures, workflows, and relevant chart of organization which focus on the prevention, detection, investigation, and reporting of suspected cases of Medicaid Fraud and Abuse within 90 days of the execution of this Agreement and then on an annual basis thereafter. These recipient verification procedures may include but not be limited to the following:

- Informing recipient in writing when goods or services have been prior authorized by the Broker
- Notifying recipient in writing when services which may require a concurrent authorization (standing orders) have been approved by the Broker

Recipient verification procedures should delineate how the Broker will respond to feedback from recipients, including any interactions with recipients who report that goods or services which had been billed by a TP or broker were not received. These procedures should address how such information from recipients will be communicated to the Broker.

Investigating and Reporting Suspected Fraud and Abuse
The Broker shall have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse. The Broker shall initiate an investigation of possible Medicaid fraud and abuse based upon a variety of data sources, including but not limited to the following:

- Claims data mining to identify aberrant billing patterns
- Feedback from recipients
- Calls received on the Broker's toll-free telephone number for reporting possible Medicaid fraud and abuse
- Peer profiling and TP credentialing functions
- Analyses of utilization management reports and prior authorization requests
- Monthly reviews of the CMS' List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM)
- Queries from State or Federal agencies

The Broker is required to report any suspected cases of TP or broker fraud and/or waste and abuse within five (5) business days following the conclusion of its initial investigation to the EOHHS Medicaid Contract Officer and/or designee as well as the Office of Program Integrity (PI). PI will review and process the referral and if warranted, submit to the Rhode Island Attorney General

MFCU and/or request additional evidence from the Broker.

The Broker, after reporting fraud or suspected fraud, shall not take any of the following actions:

- Contact the subject; or
- Negotiate any settlement or agreement; or
- Accept any monetary or other thing of valuable in connection with the incident.

The Broker will have a process for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud. The Broker shall check with both the Office of Program Integrity, (OPI) and EOHHS before initiating any recoupment related to the outcome of a program integrity audit or prior to implementing any withhold of any funds for program integrity related issues.

While all recoveries related to overpayments due to fraud, waste or abuse are retained by the Broker, the Broker will develop retention policies for the treatment of recoveries. Broker must provide an annual report of any monetary recoveries that result from reconciliation of cases of fraud.

Notifications and Tips
The Broker will utilize the State provided template to make a referral in a secure, timely, and thoughtful manner as well as to alert both EOHHS and PI of a notification or "tip." In addition to reporting any suspected cases of provider or broker fraud and/or abuse within five (5) business days following the close of an initial investigation, the Broker shall also submit quarterly reports to EOHHS documenting the Broker's open and closed cases. Along with a notification, the Broker shall take steps to triage and/or substantiate these tips and provide timely updates when the concerns and/or allegations of any tips are authenticated.

The Broker shall notify the Office of Program Integrity in a timely manner regarding all incidents and/or concerns regarding the safety of its recipients.

The Broker shall cooperate fully in any investigation or prosecution. Such cooperation shall include, but not be limited to, providing, upon request, information, access to records, and claims data.

Program Integrity Audits
The Office of Program Integrity reserves the right to conduct an annual on-site audit of the Broker's fraud and abuse/SIU unit and program integrity activities.

Damages
Broker shall use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties under this Agreement. Broker shall be liable for any loss resulting from its exercise (or failure to exercise) its powers and performance (or failure to perform) of its duties under this Agreement, up to a maximum cap of One Hundred Thousand Dollars ($100,000); provided, however, that Broker agrees to indemnify and hold harmless EOHHS from and against any and all claims, lawsuits, settlements, judgments, costs, penalties, and

expenses, including attorneys' fees, with respect to this Agreement, resulting or arising out of the dishonest, fraudulent, or criminal acts of Broker or its employees, acting alone or in collusion with others; and provided, further, that this maximum cap on damages shall not apply in the event that the loss arises in a situation in which Broker failed to follow its own policies and procedures.

Non-Compliance with Program Standards
Broker shall ensure that performance standards as described in this agreement are met in full. The size of the damages associated with failure to meet performance standards will vary depending on the nature of the deficiency. Therefore, in the event of any breach of the terms of this Agreement with respect to performance standards, unless otherwise specified, damages shall be assessed against Broker in an amount equal to the costs incurred by the State to ensure adequate service delivery to the affected recipients. Damages shall not be imposed until such time that the State has notified Broker in writing of a deficiency and has allowed a reasonable period of time for resolution.

Non-Compliance with Monthly Reconciliation Tasks
Broker shall carry out the monthly recipient reconciliation tasks as described in this agreement. Broker shall be liable for the actual amount of any detected overpayments or duplicate payments identified as a result of State or Federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect Broker action in conducting monthly recipient reconciliation.

Non-Compliance with Data Reporting Standards
Broker shall comply with the operational and financial data reporting requirements described in this agreement. Included is any ad hoc reporting requested for the purpose of investigating fraud or abuse or to validate data in the State's data warehouse. In addition, all reports provided to EOHHS will be attested to individually by the Broker. Broker shall be liable for up to two-thousand five-hundred dollars ($2,500.00) for each business day that any report is delivered after the date when it is due, or includes less than the required information, or is not in the approved media or format. Damages shall not be imposed until such time that the State has notified Broker in writing of a deficiency and has allowed a reasonable period of time for resolution.

Basis for Imposition of Intermediate Sanctions
EOHHS may impose intermediate sanctions on the Broker if it makes any of the determinations specified in paragraphs (a) through (c). The EOHHS may base its determinations on findings from onsite surveys, recipient or other complaints, financial status, or any other source.

(a) EOHHS determines that the Broker has acted or failed to act as follows:
    1. Fails substantially to provide services that the Broker is required to provide, under law or under its Agreement with the EOHHS, to a Recipient covered under this Agreement.
    2. Imposes on recipients' charges that are in excess of any permitted by the EOHHS.
    3. Acts to discriminate against Recipients on the basis of their health status or need for health care services.
    4. Misrepresents or falsifies information that it furnishes to CMS or to the EOHHS.

5. Misrepresents of falsifies information that it furnishes to a Recipient or potential Recipient.

(b) EOHHS determines that the Broker has distributed directly, or indirectly through any agent or independent broker, marketing materials that have not been approved by the EOHHS or that contain false or materially misleading information.

(c) EOHHS determines that:

1. The Broker has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations;

Types of Intermediate Sanctions

EOHHS may impose the following types of intermediate sanctions:

1. Civil monetary penalties
2. Appointment of temporary management for the Broker
3. Suspension of payment for Recipients enrolled after the effective date of the sanction and until CMS or the EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

EOHHS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance, as well as any additional areas of noncompliance.

Compliance with Other Material Contract Provisions

The objective of this standard is to provide the State with an administrative procedure to address general compliance issues under this Agreement which are not specifically defined as performance requirements listed above or for which damages due to non-compliance cannot be quantified.

The State may identify contractual compliance issues resulting from Broker's performance of its responsibilities through routine contract monitoring activities. If this occurs, the EOHHS Administrator or designee will notify Broker in writing of the nature of the performance issue. The State will also designate a period of time, not to be less than thirty (30) calendar days, in which Broker must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which Broker should remedy the non-compliance, but not less than thirty (30) days.

Deduction of Damages from Payments

Amounts due the State as damages may be deducted by the State from any money payable to Broker pursuant to this Agreement. The Contract Administrator shall notify Broker in writing of any claim for damages at least fifteen (15) days prior to the date the State deducts such sums from money payable to Broker.

The State may, at its sole discretion, return a portion or all of any damages collected as an incentive payment to Broker for prompt and lasting correction of performance deficiencies.

COMPLIANCE

The Broker shall 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 Broker'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 90 days of the execution of this Agreement and then on an annual basis thereafter.

Prohibited Affiliations with Individuals Debarred by Federal Agencies
The Broker may not knowingly have a relationship with the following:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1) of this section.

Disclosure of the Broker's Ownership and Control Interest
The Broker must submit completed forms documenting full and complete disclosure of the Broker's ownership and controlling interest, formatted in conformance with requirements established by EOHHS. Disclosures will be due at any of the following times:

(1) Upon the transportation broker submitting the proposal in accordance with the State's procurement process.

(2) Upon the transportation broker executing the contract with the State.

(3) Upon renewal or extension of the contract.

(4) Within thirty-five (35) days after any change in ownership of the transportation broker. The following information shall be disclosed by the Broker:

(1) (i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or transportation broker) or in any sub broker in which the disclosing entity (or transportation broker) has a five (5) percent or more interest.
(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or transportation broker) 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 sub broker in which the disclosing entity (or transportation broker) 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.

(3) The name of any other disclosing entity (or transportation broker) in which an owner of the disclosing entity (or transportation broker) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or transportation broker).

The Broker must keep copies of all ownership and control interest requests from EOHHS and the Broker's responses to these disclosure requests. Copies of these requests and the Broker'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 Broker 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.

Disclosure by Providers: Information on Ownership and Control

The Broker must require each disclosing entity to disclose the following information:

(1) (i) The name and address and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or transportation broker) or in any sub broker in which the disclosing entity (or transportation broker) has a five (5) percent or more interest.

(2) 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 sub broker 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.

(3) The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

An individual is considered to have an ownership or control interest in a provider entity if it has

direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity part thereof, or who directly or indirectly conducts the day-to- day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR Section 1001.1001(a)(1).

Any disclosing entity that is subject to periodic certification by the Broker of compliance with Medicaid standards (such as at the time of initial credentialing and re-credentialing by the Broker) must supply the information as specified in this section in conformance with requirements established by the EOHHS. Any disclosing entity that is not subject to periodic certification of its compliance within the prior 12-month period must submit the information to the Broker before entering into a contract or agreement with the Broker.

Disclosures must also be provided by any provider or disclosing entity 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 Broker shall not approve a transportation 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.

Disclosure by Providers: Information Related to Business Transactions
The Broker must enter into an agreement with each TP 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 sub broker with whom the provider has had business transactions totaling more than twenty-five thousand ($25,000) dollars during the 12-month period ending on the date of request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any sub broker during the five year period ending on the date of the request.

This information must be submitted by a provider or a sub broker 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.

Disclosure by Providers: Information on Persons Convicted of Crimes
Before the Broker enters into or renews a provider agreement, or at any time upon written request by EOHHS, the provider must disclose the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX program since the inception of those programs.

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of five (5) percent or more, or is a managing employee (such as a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day- to-day operations of the entity or part thereof, as defined in section 1126(b) of the Social Security Act and under 42 CFR 1001.1001(a)(1).

The Broker shall promptly notify EOHHS in writing within ten (10) business days in the event that the Broker identifies an excluded individual with an ownership or control interest.

The Broker 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 Broker 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.

Disclosures Made by Providers to the Broker

Before the Broker enters into or renews a provider agreement, or at any time upon written request by EOHHS, the Broker shall disclose to EOHHS in writing the identity of any person who:

(A) Has been convicted of a criminal offense as described in Sections 1128(a) and 1182(b) (1), (2), or (3) of the Social Security Act

(B) Has had civil money penalties or assessments imposed under Section 1129A of the Social Security Act; or

(C) Has been excluded from participation in Medicare, Medicaid, or any Federal or State health care programs and such a person has:

(1) a direct or indirect ownership interest of five (5) percent or more in the entity;

(2) Is the owner of a whole or part interest in any mortgage, deed of trust, note for other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceed five (5) percent of the total property and assets of the entity;

(3) Is an officer or director of the entity, if the entity is organized as a corporation;

(4) Is partner in the entity, if the entity is organized as a partnership;

(5) Is an agent of the entity; or

(6) Is a managing employee, that is (including a general manager, business

manager, administrator or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof, or was formerly described in paragraph (a)(1)(ii)(A) of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family recipient or a recipient 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 recipient, indirect ownership interest, recipient of household, and ownership interest) shall have the meaning specified in 42 CFR 1001.1001.

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family recipient 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.)

Recipient 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 recipient of household.

Ownership interest means an interest in:

(i) The capital, the stock, or the profits of the entity, or

(ii) Any mortgage, deed, trust or note, or other obligation secured in whole or party by the property or assets of the entity.

The Broker must notify EOHHS in writing within ten (10) business days of the receipt of any disclosures which have been made to the Broker.

The Broker must promptly notify EOHHS in writing within ten (10) business days of any action that it takes to deny a TP'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 Broker's concern about Medicaid program integrity or quality).

The Broker must also promptly notify EOHHS 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 Broker'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 Broker 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 Broker 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.

Compliance with all Rhode Island Regulations

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

1. 2019 Enacted Budget: The Broker's capitation rates include dollars allocated from the SFY 2019 Enacted Budget.

Compliance with all Federal Regulations

The Broker agrees to comply with all applicable Federal laws and regulations.

GRIEVANCE AND APPEALS

EOHHS has established a Grievance and Appeals function through which recipients can seek redress against the Broker. The grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. For its part, Broker shall have written policies and procedures conforming to EOHHS' requirements for resolving recipient complaints and for processing grievances, when requested by the recipient or when the time allotted for complaint resolution expires. Such procedures shall not be applicable to any disputes that may arise between Broker and provider regarding the terms, conditions, or termination or any other matter arising under a participation agreement or regarding any payment or other issues relating to providers. Broker agrees to participate in State Fair Hearings upon request.

Broker's policies and procedures for processing grievances must permit a recipient, TP or authorized representative, acting on behalf of the recipient and with the recipient's written consent, to file a grievance with the Broker at any time. The timeframe for resolution is 90 calendar days from receipt of the grievance.

Broker's policies and procedures for processing appeals must permit a recipient, TP or authorized representative acting on behalf of the recipient and with the recipient's written consent, to file an appeal of an action within 60 calendar days from the date on the Broker's notice of action. An action means: (1) whether or not a service is a Covered Service; (2) the denial or limited authorization of a requested service, including the type or mode of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, as defined in this Agreement.

A Notice of Action must be in writing and must explain:

- The action Broker, or its agents, has taken or intends to take
- The reasons for the action, including the right of the recipient to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse service determination.
- The recipient or TP's right to file an appeal with the Broker, including information on exhausting the Broker's one level of appeal and the right to request a State Fair Hearing
- The procedures for exercising the rights in this section
- The circumstances under which expedited appeal resolution is available and how to request it
- The recipient's rights to have covered benefits continue pending resolution of the appeal and the final decision of EOHHS.

Broker must mail the notice of action to the recipient. Written materials must use easily understood language and that recipients are informed that alternative formats available for those with special needs who may be visually limited or have limited reading proficiency. All written material must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information. Written notices must be translated in each prevalent non-English language for recipients who speak non-English languages. Such notices must include a statement that oral interpretations for recipients are available in all languages.

In handling grievances and appeals, Broker must:

- Give recipients any reasonable assistance in completing forms and taking procedural steps, including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- Allow recipients to file grievance or appeal verbally which may be confirmed in writing.
- Acknowledge each grievance and appeal within five (5) calendar days.
- Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.

For appeals, the process must: (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date); (b) provide the recipient a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the recipient and his or her representative opportunity, before and during the appeals process, to examine the case file.

Broker must provide written notice of the disposition of all standard appeals within thirty (30) calendar days, from the time the Broker receives the appeal. This timeframe may be extended by up to 14 calendar days if the recipient requests an extension or if the Broker shows (to the satisfaction of EOHHS upon request) that there is need for additional information and how the delay is in the recipient's best interest. If the Broker extends the timeframes not at the request of the recipient, it must complete all the following:

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

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

Each written notice of determination must include the following:

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

If the Broker takes an action and the recipient requests a State Fair Hearing within one hundred and twenty (120) calendar days of the Broker's notice of resolution, the State must grant the recipient a State Fair Hearing, after the recipient has exhausted the Broker's internal appeals procedures. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the recipient by the Broker.

If the Broker, State Fair Hearing officer or external reviewer reverses the decision to deny, limit,

or delay services that were not furnished while the appeal was pending, Broker must authorize or provide the disputed services promptly, no later than 72 hours from the date it receives notice reversing the determination.

Broker is required to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures.

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

(1) A general description of the reason for the appeal or grievance.
(2) The date received.
(3) The date of each review or, if applicable, review meeting.
(4) Resolution at each level of the appeal or grievance, if applicable.
(5) Date of resolution at each level, if applicable.
(6) Name of the recipient for whom the appeal or grievance was filed.
(c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS

Complaint Resolution
It is EOHHS's preference that the Broker resolves recipient and TP complaints through internal mechanisms whenever possible. Broker, therefore, agrees to have written policies and procedures for handling complaints registered by recipient and TPs. As part of the process, Broker agrees to record and maintain a log of all complaints received, the date of their filing, and their current status and provide reports as requested.

Grievance Process
A grievance is a formal expression of dissatisfaction about any matter other than an "action". A recipient may file a grievance with the Broker either orally or in writing. The Broker must dispose of each grievance and provide notice in writing within ninety (90) calendar days from the day the Broker receives the grievance.

Expedited Resolution of Appeals
Broker must establish and maintain an expedited review process for appeals. Broker must resolve a request for expedited appeal and notify affected parties of the resolution within 72 hours after Broker receives the request. Broker may extend the timeframe by up to fourteen (14) calendar days, if the recipient or TP request the extension, or Broker can show (to the satisfaction of EOHHS, upon EOHHS's request) that there is need for additional information and how the delay is in the recipient's interest. This request must be in writing to the recipient.

Broker must ensure that punitive action is not taken against a TP who requests an expedited resolution or who supports a recipient's request.

ANNUAL COMPLIANCE AUDIT

The Annual Compliance Audit will be onsite and consists of a focused review of key elements of the Broker's compliance program and will assess adherence to the Broker's written compliance plan including all relevant operating policies, procedures, workflows, and relevant chart of organization. The key elements reviewed may vary from year to year. A review of administrative and management arrangements may also be conducted as part of the annual audit. A review of grievance and appeal files will be a standard part of the compliance audit.

While the findings of the compliance audit will not be scored, EOHHS will provide necessary feedback on each of the key elements. If the findings indicate that the Broker is out of compliance, EOHHS will make the determination of whether a corrective action plan is warranted.

INSPECTION OF WORK PERFORMED

Access to Information

EOHHS, other state agencies, and/or its designees, including its management and external quality review organization brokers, the Medicaid Fraud Unit of the Department of Attorney General, and CMS and/or its designees, shall have access to quality of service information, financial information (including claim level detail), service delivery information including authorization requests and denials or other adverse decisions, complaints, grievances and appeals information, and other such information of Broker, and its sub brokers and agents in order to evaluate through inspection or other means, the quality, and timeliness of services performed and reimbursed for under this Agreement and in compliance with this Agreement. Broker agrees to accommodate requests for access to this information which may be submitted at any time. Sub brokers must agree to comply with all applicable requirements, such as those pertaining to reporting responsibilities, record-keeping, state and federal audits. For audit purposes, sub brokers are subject to a 10-year record retention period for which EOHHS may request access to.

Inspection of Premises

The State Executive Office of Health and Human Services, the State Department of Health, State Auditor of Rhode Island, the U.S. Department of Health and Human Services, Government Accountability Office, the Comptroller General of the United States, the U.S. Office of the Inspector General, Medicaid Fraud Control Unit of the State Department of the Attorney General or their authorized representatives shall, during normal business hours, have the right to enter into the premises of Broker and/or all sub brokers and providers, or such other places where duties under this Agreement are being performed, to inspect, monitor, or otherwise evaluate the work being performed.

Such inspections may include, but not be limited to, the CMS or State-mandated annual operational and financial reviews, determinations of compliance with this Agreement, and CMS or State-mandated independent evaluations. All inspections and evaluations shall be performed in such a manner as to not unduly interfere with or delay work.

Marketing

Broker agrees to submit to EOHHS for review and written approval all materials, in any media, and any other materials associated with marketing that will be distributed to recipients or

potential recipients before they are distributed. Materials developed or distributed by sub brokers or providers also require review and approval before being distributed. Recipient materials include, but are not limited to recipient handbooks, provider directories, newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, newspaper, TV and radio advertisements, call scripts, surveys and other materials as identified by EOHHS. Broker agrees to submit marketing strategy and plans if requested.

Approval of Written Materials
Broker agrees to submit to EOHHS for review and approval all materials in any media. Broker produces for dissemination to actual and potential recipients including but not limited to materials produced for recipient education, outreach, marketing, the recipient handbook, and written grievance procedures. EOHHS shall review such documents in draft form and determine whether to grant approval for Broker to disseminate such documents to the recipient population.

Broker's policies and procedures pertaining to the program covered under this Agreement produced for dissemination to actual and potential recipients, including but not limited to procedures for determining eligibility for coverage as a related group, also shall be subject to inspection and approval by the State.

Communication

- The Broker shall not distribute any oral or written materials to recipients without receiving written approval by the EOHHS.

- The Broker shall provide written and oral information that adequately educates health care providers, provider associations, community-based organizations and consumer representatives.

- The Broker shall emphasize the availability of transportation services, eligibility for these services, the authorization process for single trips and standing orders, medical documentation of need, and how to access and use these services properly.

- On-going collaboration with medical providers, adult day care providers, nursing homes, dialysis centers and methadone treatment clinics, and other medical provider facilities to achieve transportation efficiencies.

The broker's plan should include information on the outreach, education and marketing. This material:

- Must include culturally sensitive materials produced at least in English and Spanish;

- Must be written at a sixth=grade reading level; and

- All correspondence developed by the Broker must be reviewed and approved by the EOHHS prior to distribution.

The broker shall provide such materials and distribution plan to EOHHS for its review and

approval within sixty days (or alternate date as agreed by EOHHS) from the execution of a contract. The broker is encouraged to develop supplemental written materials for recipients, health care providers, provider associations, community-based organizations and consumer representatives. All materials developed by the broker for distribution require prior written approval by EOHHS. EOHHS requires at least ten (10) business days to review and approve materials. Materials must be approved at least ten (10) business days before distribution.

Recipient Communication

The Broker is responsible for developing the initial recipient notification regarding transportation services availability and advance scheduling prior to the Broker assuming responsibility for the provision of transportation services. A Recipient Education Plan must be developed for recipients that include each recipient's rights and responsibilities for use of transportation services. All notices and information materials used by the Broker shall be reviewed and receive written approval by the EOHHS prior to mailing or otherwise disseminated.

Partner/Stakeholder Communication/Engagement

Written and oral information must adequately educate health care providers, provider associations, community-based organizations and consumer representatives. Education shall emphasize the availability of transportation services, eligibility for these services, the authorization process for single trips and standing orders, medical documentation of need, and how to access and use these services properly.

EOHHS Requested Communication

The Broker will be required to periodically participate and provide transportation related information at community and regional meetings as requested by the EOHHS. Information provided may include details on how to access services, recipient and provider rights, responsibilities, complaint procedures, and other information as specified by the EOHHS.

Languages Other Than English

EOHHS will maintain a methodology for identifying the prevalent non-English languages spoken by recipients and potential recipients throughout the State. The Broker must make verbal interpretation available in all languages and written translation available in each prevalent non-English language. All written materials for potential recipients must include taglines in the prevalent non-English languages in the State, as well as large print (18 point), explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a). This must be added to any letter they may use that explains recipient's right to the State Fair Hearing process as a result of having their level of service decreased or denied.

The Broker shall make interpretation services available to each recipient and make those services available free of charge to each recipient. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.

Written materials must use easily understood language. The Broker must ensure that recipients are informed that alternative formats are available for those with special needs who may be visually limited or have limited English proficiency. All written materials for recipients must include taglines in the prevalent non-English languages in the State, as well as large print (18 point), explaining the availability of written translations or verbal interpretation to understand the information provided and the toll-free telephone number to call for assistance. All recipients must be informed that information is available in alternative formats and how to access those formats. Verbal interpretations must be available to recipients in all languages.

1. The notice must be in writing and must meet the following language requirements:
    a) The Broker in conjunction with EOHHS shall identify the non-English languages prevalent (i.e. spoken by a significant number or percentage of the recipient's and potential population);
    b) The Broker must make available written information in each prevalent non-English language;
    c) The Broker must make verbal interpretation services available for all languages free of charge and;
    d) The Broker must notify recipients that verbal interpretation is available for any language.

CONFIDENTIALITY OF INFORMATION

Maintain Confidentiality of Information

The Broker shall take security measures to protect against the improper use, loss, access of and disclosure of any confidential information it may receive or have access to under this Agreement as required by this Agreement, the RFP and proposal, or which becomes available to the Broker in carrying out this Agreement, the RFP and the proposal, and agrees to comply with the requirements of the EOHHS for safeguarding of client and such aforementioned information. Confidential information includes, but is not limited to: names, dates of birth, home and/or business addresses, social security numbers, protected health information, financial and/or salary information, employment information, statistical, personal, technical and other data and information relating to the State of Rhode Island data, and other such data protected by the office laws, regulations and policies ("confidential information"), as well as State and Federal laws and regulations. All such information shall be protected by the Broker from unauthorized use and disclosure and shall be protected through the observance of the same or more effective procedural requirements as are applicable to the EOHHS.

The Broker expressly agrees and acknowledges that said confidential information provided to and/or transferred to provider by the EOHHS or to which the Broker has access to for the performance of this Agreement is the sole property of the EOHHS and shall not be disclosed and/or used or misused and/or provided and/or accessed by any other individual(s), entity(ies) and/or party(ies) without the express written consent of the EOHHS. Further, the Broker expressly agrees to forthwith return to the EOHHS any and all said data and/or information and/or confidential information and/or database upon the EOHHS's written request and/or cancellation and/or termination of this Agreement.

The Broker shall not be required under the provisions of this paragraph to keep confidential any data or information, which is or becomes legitimately publicly available, is already rightfully in the Broker's possession, is independently developed by the Broker outside the scope of this Agreement or is rightfully obtained from third parties under no obligation of confidentiality.

The Broker agrees to abide by all applicable, current and as amended Federal and State laws and regulations governing the confidentiality of information, including to but not limited to the Business Associate requirements of HIPAA (WWW.HHS.GOV/OCR/HIPAA), to which it may have access pursuant to the terms of this Agreement. In addition, the Broker agrees to comply with the EOHHS confidentiality policy recognizing a person's basic right to privacy and confidentiality of personal information. ("Confidential records" are the records as defined in section 38-2-3(d) of the Rhode Island General Laws, entitled "access to public records" and described in "access to Department of Health records.")

In accordance with this Agreement and all Addenda thereto, the Broker will additionally receive, have access to, or be exposed to certain documents, records, that are confidential, privileged or otherwise protected from disclosure, including, but not limited to: personal information; Personally Identifiable Information (PII), Sensitive Information (SI), and other information (including electronically stored information), records sufficient to identify an applicant for or recipient of government benefits; preliminary draft, notes, impressions, memoranda, working papers and work product of state employees; as well as any other records, reports, opinions, information, and statements required to be kept confidential by state or federal law or regulation, or rule of court ("State Confidential Information"). State Confidential Information also includes PII and SI as it pertains to any public assistance recipients as well as retailers within the SNAP Program and Providers within any of the State Public Assistance programs.

Personally Identifiable Information (PII) is defined as any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual.

Sensitive Information (SI) is information that is considered sensitive if the loss of confidentiality, integrity, or availability could be expected to have a serious, severe or catastrophic adverse effect on organizational operations, organizational assets, or individuals. Further, the loss of sensitive information, confidentiality, integrity, or availability might: (i) cause a significant or severe degradation in mission capability to an extent and duration that the organization is unable to perform its primary functions; (ii) result in significant or major damage to organizational assets; (iii)result in significant or major financial loss; or (iv) result in significant, severe or catastrophic harm to individuals that may involve loss of life or serious life-threatening injuries. (Defined in HHS Memorandum ISP-2007-005, "Departmental Standard for the Definition of Sensitive Information").

The Broker agrees to adhere to any and all applicable State and Federal statutes and regulations relating to confidential health care and Substance Use treatment including but not limited to the Federal Regulation 42 CFR, Part 2; Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26; Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq, and HIPAA 45 CFR Part 160[liv]. The Broker acknowledges that failure to comply with the provisions of this paragraph will result in the termination of this Agreement.

EOHHS requires the Broker to adhere to the provisions of the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, as well as guidelines found in the "Health Information Technology for Economic and Clinical Health Act" (HITECH). The Broker shall require HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information and must specify the requirements of these notifications to the HIPAA covered entities and business associates. In addition, EOHHS requires the Broker to notify EOHHS immediately upon becoming aware of any incident, either confirmed or provisional, that represents or may represent unauthorized access, use of disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality or integrity of recipient PHI maintained or held by the Broker, including unauthorized acquisition of recipient PHI by an employee or otherwise authorized user of the Broker's system. Additionally, a breach or suspected breach may be an actual or suspected acquisition, access, use of, or disclosure of PII or SI. This includes, but is not limited to, loss or suspected loss of remote computing or telework devised such as laptops, PDAs, Blackberrys or other Smartphones, USB drives, thumb drives, flash drives, CDs and/or disks. Notification to EOHHS' designated security officer shall be made by telephone call and e-mail. The Broker shall, within three (3) business days, provide to the EOHHS's designated security officer an updated status of the breach. A full report is required to be submitted to EOHHS's designated security officer within sixty (60) calendar days and will include a full accounting of the incident along with a corrective action plan.

Upon notice of a suspected security incident, the EOHHS and Broker will meet to jointly develop an incident investigation and remediation plan. Depending on the nature and severity of the confirmed breach, the plan may include the use of an independent third-party security firm to perform an objective security audit in accordance with recognized cyber security industry commercially reasonable practices. The parties will consider the scope, severity and impact of the security incident to determine the scope and duration of the third party audit. If the parties cannot agree on either the need for or the scope of such audit, then the matter shall be escalated to senior officials of each organization for resolution. The Broker will pay the costs of all such audits. Depending on the nature and scope of the security incident, remedies may include, among other things, information to individuals on obtaining credit reports and notification to applicable credit card companies, notification to the local office of the Secret Service, and or affected users and other applicable parties, utilization of a call center and the offering of credit monitoring services on a selected basis.

Notwithstanding any other requirement set out in this Agreement, the Broker acknowledges and agrees that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the U.S. Department of Health and Human

Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this Agreement as if set forth in this Agreement in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and its implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

Failure to abide by the EOHHS's confidentiality policy or the required signed Business Associate Agreement (BAA) will result in termination remedies, including but not limited to, termination of this Agreement. A Business Associate Agreement (BAA) shall be signed by the Broker, simultaneously or as soon thereafter as possible, from the signing of this Agreement, as required by the EOHHS.

The Broker agrees to comply with the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42U.S.C. Section 1320d, et seq., and regulations promulgated there under, as amended from time to time (statute and regulations hereinafter collectively referred to as the "privacy rule").

The Broker's obligations and responsibilities:

(a) Broker agrees to not use or disclose protected health information other than is permitted or required by the agreement or as required by law.

(b) Broker agrees to use appropriate and most updated industry safeguards to prevent use or disclosure of the protected health information other than as provided by this agreement.

(c) Broker agrees to mitigate, to the extent practicable, any harmful effect that is known to the Broker of a use or a disclosure of protected health information by the Broker in violation of requirement of this Agreement.

(d) Broker agrees to report to EOHHS any use or disclosure of the protected health information not provided for by this Agreement of which it becomes aware.

(e) Broker agrees to maintain the security of protected health information it receives by establishing, at a minimum, measures utilized in current industry standards.

(f) Broker agrees to notify EOHHS immediately upon becoming aware of a suspected or actual breach of security that may result or has resulted in the use or disclosure of protected health and other confidential information for purposes other than such proposed as specified in this Agreement.

(g) Broker agrees to prepare and maintain a plan, subject to review by EOHHS /DoIT upon request, specifying the method that the Broker will employ to mitigate immediately, to extent practicable, any harmful effects that may or have been caused by such a breach.

(h) Broker agrees that EOHHS shall be held harmless in the event of such a breach and the Broker accepts fully the legal and financial responsibility associated with mitigating any harmful effects that may or have been caused.

(i) Broker agrees that it is subject to and shall ensure compliance with all HIPAA regulations in effect at the time of this Agreement and as shall be amended under HIPAA from time to time, and any and all reporting requirements required by HIPAA at the time of this Agreement and as shall be amended, under HIPAA from time to time. As well as ensuring compliance with the Rhode Island Confidentiality of Health Care Information Act, Rhode Island General Laws, Section 5-37.3 seq.

(j) Broker agrees to implement policies and procedures to facilitate the removal, termination and final disposal of PHI in electronic format, including the storage media housing the information.

Assurance of Security and Confidentiality
Each party agrees to take reasonable steps to ensure the physical security of such data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files; guards; or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; such as passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; such as limited terminal access; limited access to input documents and output documents; and design provisions to limit use of client or applicant names.

Each party agrees that it will inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

In the event of Broker's failure to conform to requirements set forth above, EOHHS may terminate this Agreement under the provisions of Section 2.19 (Termination of the Contract).

Return of Confidential Data
Broker agrees to return all personal data furnished pursuant to this Agreement promptly at the request of the State in whatever form is maintained by Broker. Upon the termination or completion of the Agreement, Broker will not use any such data or any material derived from the data for any purpose not permitted by law and where so instructed by the State will destroy such data or material if permitted by law.

State Assurance of Confidentiality
The State agrees to ensure Federal and State laws of confidentiality are maintained to protect recipient and provider information.

Publicizing Safeguarding Requirements
Broker agrees to publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use. Broker shall include these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

Types of Information to Be Safeguarded
Broker agrees to maintain the confidentiality of recipient information regarding at least the following:

- Names, addresses, and social security numbers
- Physical and behavioral health services utilized
- Social and economic conditions or circumstances
- EOHHS evaluations of personal information and,
- Any information received in connection with the identification of legally liable third-party resources

The State agrees to maintain the confidentiality of recipient information regarding at least the following:

- Any information received for verifying income eligibility and amount of Medicaid payments
- Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data

Confidentiality and Protection of Public Health Information and Related Data
The Broker shall be required to execute a Business Associate Agreement Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, shall require the successful Broker to comply with 45 CFR 164.502(e), 164.504(e), 164.410, governing Protected Health Information ("PHI") and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated there under, and as amended from time to time the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, RI general Laws Section 5-37.3 et seq.

Notwithstanding anything to the contrary or any provision that may be more restrictive within this Agreement, all requirements and provisions of HITECH, and implementing regulations currently in effect and promulgated and/or implemented after the date of this Agreement, are automatically effective and incorporated herein. Where this Agreement requires stricter guidelines, the stricter guidelines must be adhered to.

The Broker shall be required to ensure, in writing that any agent including a sub broker, to whom it provides Protected Health Information received from, or created or received by and/or through this Agreement, agrees to have the same restrictions and conditions that apply through the above described Agreements with respect to such information.

TERMINATION OF THE CONTRACT

This Agreement between the parties may be terminated only on the following basis:

- By mutual written agreement of the State and Broker

- By the State, or by the Broker, in whole or in part, whenever one party determines that the other party has failed to satisfactorily perform its contracted material duties and responsibilities and is unable to cure such failure within a reasonable period of time after receipt of a notice specifying that material breach.

- By the State, or Broker, in whole or in part, whenever funding from State, Federal, or other sources is withdrawn, reduced, or limited, with at least sixty (60) days prior written notice.

- By the State, in whole or in part, whenever the State reasonably determines, based on adequate documentation, that the instability of Broker's financial condition threatens delivery of covered services and continued performance of Broker responsibilities.

- Upon a finding of just cause, if the State shall determine that such termination is in the best interest of the State, with sufficient prior notice to Broker.

Termination for Default
The State or Broker may terminate this Agreement, in whole or in part, whenever either reasonably determines that the other party has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within a reasonable period of time as specified in writing by the State or Broker, as applicable. Such termination shall be referred to herein as "Termination for Default."

Upon reasonable determination by the State or Broker that the other party (the "Defaulting Party") has failed to satisfactorily perform its contracted duties and responsibilities, the Defaulting Party shall be notified in writing, by either certified or registered mail, of the failure. If the Defaulting Party is unable to cure the failure within sixty (60) days following the receipt of notice of default, unless a different time period is agreed to by the parties in writing, the State or Broker, as applicable, will notify the Defaulting Party that this Agreement, in whole or in part, has been terminated for default.

If, after notice of Termination for Default, it is determined by the State or Broker, as applicable, or by a court of law of competent jurisdiction that the Defaulting Party was not in default or that the Defaulting Party's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Defaulting Party, the termination shall be deemed to be governed by Section 3.05.09 (Force Majeure) of this Agreement.

In the event of termination for default by the State, in full or in part as provided under this clause, the State may cover, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and Broker shall be liable for any costs for

such similar supplies or services and all other damages allowed by law. In addition, Broker shall be liable to the State for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. Payment for such costs may be assessed against Broker's performance bond or substitute security.

In the event of a termination for default by the State, Broker shall be paid for any outstanding monies due less any assessed damages. If damages exceed monies due from invoices, collection can be made from Broker's performance bond, cash deposit, letter of credit, or substitute security.

The rights and remedies of the State provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the contract.

In the event of Termination for Default by Broker, in whole or in part as provided under this clause, Broker immediately may close to new enrollment that has been initiated but not yet completed as of the date specified in the notice of termination), without reduction of the premium rate for the then-current recipients as provided in ATTACHMENT A. Broker shall be paid for any capitation or other monies due through the date specified in the notice of termination, including risk sharing payment, within 90 days of termination. The rights and remedies of Broker provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

Any fraudulent activities may result in criminal prosecution.

Termination for Unavailability of Funds

In the event funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated contract expiration date, the State may terminate this Agreement upon at least thirty (30) days prior written notice.

In the event that the State elects to terminate this Agreement pursuant to this provision, Broker shall be notified in writing by either certified or registered mail either thirty (30) days or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice.

Upon receipt of notice of termination for unavailability of funds, Broker shall be paid for any outstanding monies due.

Termination for Financial Instability

In the event that the State reasonably determines, based on adequate documentation, that Broker becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under this Agreement, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Agreement effective the close of business on the date specified. In the event the State elects to terminate this Agreement under this provision, Broker shall be notified in writing by either certified or registered mail specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal sub broker, Broker shall immediately advise the Contract Administrator. Broker shall ensure that all tasks related to the subcontract are

performed in accordance with the terms of this Agreement.

Termination for Convenience
Upon written notice sent via certified mail to the EOHHS Officer, the Broker may seek to terminate this Agreement with the EOHHS without cause. The Broker shall have a transition period of not less than four (4) nor more than six (6) months to transition services, during which time the term and conditions of this Agreement shall continue to apply, and the Broker shall provide Covered Services to, and shall be paid pursuant to the Capitation Rates set forth herein for each Recipient, up to and including the date of transition of such Recipient.

Procedures on Termination
Upon delivery by certified or registered mail to Broker of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective or upon expiration of this Agreement, Broker shall:

- Stop work under this Agreement on the date and to the extent specified in the Notice of Termination or upon expiration of this Agreement.
- With the approval of the State, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts or from such expiration, the cost of which would be reimbursable in whole or in part, in accordance with the provision of this Agreement.

- If applicable, complete the performance of such part of the work as has not been terminated by any Notice of Termination.

- Provide all reasonably necessary assistance to the State in transitioning recipients out of the transportation service generally, upon expiration of the Agreement, or to the extent specified in the Notice of Termination.

- Provide to the State on a monthly basis, until the earlier of six (6) months from the termination or expiration or instructed otherwise, a monthly claims aging report by provider. Such reports will be due on the fifteenth (15th) working day of each month for the prior month.

Refunds of Advance Payments
Broker shall return within thirty (30) days of receipt any funds advanced for coverage of recipients for periods after the date of termination or expiration.

Notification of recipients
In the event that this Agreement is terminated for any reasons outlined in above, or in the event that this Agreement is not renewed for any reason, EOHHS in consultation with Broker regarding the content of any notice (such consultation to occur prior to the sending of any notice) shall be responsible for notifying all recipients covered under this Agreement of the date of termination and the process by which those recipients will continue to receive Covered Services.

Non-Compete Covenant
EOHHS may cancel this Agreement without penalty, if any person significantly involved in negotiating, securing, drafting, or creating this Agreement on behalf of the State is or becomes at any time, while this Agreement or any extension of this Agreement is in effect, an employee of any party to this Agreement in any capacity or a consultant to Broker or Sub broker with respect to the subject matter in this Agreement. Cancellation shall be effective when written notice from EOHHS is received by Broker unless the notice specifies a later time.

OTHER CONTRACT TERMS AND CONDITIONS

Environmental Protection
Broker shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 1857(h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR, Part 15) which prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. Broker shall report violations to the applicable grantor Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

Ownership of Data and Reports
Data, information, and reports collected or prepared directly for the State by Broker in the course of performing its duties and obligations under this Agreement shall be deemed to be owned by the State of Rhode Island. This provision is made in consideration of Broker's use of public funds in collecting or preparing such data, information, and reports. Nothing contained herein shall be deemed to grant to the State ownership or other rights in Broker's proprietary information systems or technology used in conjunction with this Agreement.

Publicity
Any publicity given to the program or services provided herein, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for Broker, shall identify the State of Rhode Island as the sponsor and shall not be released without prior written approval from the State.

Award of Related Contracts
The State may undertake other contracts for work related to this Agreement or any portion thereof. Examples of other such contracts include, but are not limited to, contracts with other Transportation Brokers to provide transportation services and contracts with management firms to assist in the administration of this Agreement. Broker shall be bound to cooperate fully with such other Brokers as directed by the State in all such cases. All sub brokers will be required to abide by this provision as a condition of the contract between the sub broker and the prime Broker.

Conflict of Interest
No official or employee of the State of Rhode Island or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of this Agreement shall, prior to the completion of the project, voluntarily acquire any personal interest,

direct or indirect, in the contract or proposed contract. All State employees shall be subject to the provisions of Chapter 36-14 of the General Laws of Rhode Island.

Broker represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Broker further covenants that, in the performance of the contract, no person having any such known interests shall be employed.

Reporting of Political Contributions
In accordance with Rhode Island Executive Order 91-31, any Broker who obtains a State contract or purchase order for goods or services, and whose charges to the State exceed two thousand five hundred dollars ($2,500.00) in any State fiscal year, is required to file a form declaring the broker's political contributions in excess of two hundred dollars ($200.00) to candidates for State offices or the General Assembly. Upon payment to a Broker being made in excess of two thousand five hundred dollars ($2,500.00) year-to-date, Broker will receive a form prepared by the Secretary of State upon which to make such declaration. Broker shall update such form as future political contributions subject to this reporting requirement are made. Failure to complete or update said form accurately, completely, and in conformance with its terms, or to file it with the Secretary of State within sixty (60) days of receipt, will amount to a violation of these terms and conditions and may render Broker ineligible for further State contracts. Additional disclosure forms, as may be required, may be obtained from the office of the Secretary of State.

Environmental Tobacco Smoke
Broker shall comply with Public Law 103-227, Part C—Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

Titles Not Controlling
Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

Other Contracts
Nothing contained in this Agreement shall be construed to prevent Broker from operating other comprehensive transportation services to persons other than those covered hereunder; provided, however, that Broker shall provide EOHHS with a complete list of such services, including rates, upon request. Nothing in this Agreement shall be construed to prevent EOHHS from contracting with other comprehensive transportation brokers in the same service area. EOHHS shall not disclose any proprietary information pursuant to this information except as required by law.

Counterparts
This Agreement may be executed simultaneously in two or more counterparts each of which will be deemed an original and all of which together will constitute one and the same instrument.

Administrative Procedures Not Covered
Administrative procedures not provided for in this Agreement will be set forth where necessary in separate memoranda from time to time in accordance with this agreement.

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

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES:

BY: _____
(Signature)

_____
(Official Title)

_____
(Date)

:

BY: _____
(Signature)

_____
(Official Title)

_____
(Date)

ADDENDUM I

FISCAL ASSURANCES

1. THE BROKER AGREES TO SEGREGATE ALL RECEIPTS AND DISBURSEMENTS PERTAINING TO THIS AGREEMENT FROM RECEIPTS AND DISBURSEMENTS FROM ALL OTHER SOURCES, WHETHER BY SEPARATE ACCOUNTS OR BY UTILIZING A FISCAL CODE SYSTEM.

2. THE BROKER ASSURES A SYSTEM OF ADEQUATE INTERNAL CONTROL WILL BE IMPLEMENTED TO ENSURE A SEPARATION OF DUTIES IN ALL CASH TRANSACTIONS.

3. THE BROKER ASSURES THE EXISTENCE OF AN AUDIT TRAIL WHICH INCLUDES: CANCELLED CHECKS, VOUCHER AUTHORIZATION, INVOICES, RECEIVING REPORTS, AND TIME DISTRIBUTION REPORTS.

4. THE BROKER ASSURES A SEPARATE SUBSIDIARY LEDGER OF EQUIPMENT AND PROPERTY WILL BE MAINTAINED.

5. THE BROKER AGREES ANY UNEXPENDED FUNDS FROM THIS AGREEMENT ARE TO BE RETURNED TO THE DEPARTMENT AT THE END OF THE TIME OF PERFORMANCE UNLESS THE DEPARTMENT GIVES WRITTEN CONSENT FOR THEIR RETENTION.

6. THE BROKER ASSURES INSURANCE COVERAGE IS IN EFFECT IN THE FOLLOWING CATEGORIES: BONDING, VEHICLES, FIRE AND THEFT, LIABILITY AND WORKER'S COMPENSATION.

7. THE FOLLOWING FEDERAL REQUIREMENTS SHALL APPLY AS INDICATED:

   - OMB CIRCULAR A-21 COST PRINCIPLES FOR EDUCATIONAL INSTITUTIONS

   - OMB CIRCULAR A-87 COST PRINCIPLES APPLICABLE TO GRANTS AND CONTRACTS WITH STATE AND LOCAL GOVERNMENTS

   - OMB CIRCULAR A-102 UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS-TO-AID TO STATE AND LOCAL GOVERNMENTS

   X OMB CIRCULAR A-110 UNIFORM ADMINISTRATIVE

REQUIREMENTS FOR GRANTS AND AGREEMENTS WITH INSTITUTIONS OF HIGHER EDUCATION, HOSPITALS, AND OTHER NONPROFIT ORGANIZATIONS

X OMB CIRCULAR A-122 COST PRINCIPLES FOR NONPROFIT ORGANIZATIONS

8. IF THE BROKER EXPENDS FEDERAL AWARDS DURING THE PROVIDER'S PARTICULAR FISCAL YEAR OF $500,000 OR MORE, THEN OMB CIRCULAR A-133, AUDITS OF STATES, LOCAL GOVERNMENTS AND NON-PROFIT ORGANIZATIONS SHALL ALSO APPLY.

9. THIS AGREEMENT MAY BE FUNDED IN WHOLE OR IN PART WITH FEDERAL FUNDS. IF SO, THE CFDA REFERENCE NUMBER IS 93.778.

ADDENDUM II

NOTICE TO EOHHS BROKERS OF THEIR RESPONSIBILITIES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH EOHHS ARE SUBJECT TO THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH IS LOCATED AT 45 CFR, PART 80, COLLECTIVELY REFERRED TO HERINAFTER AS TITLE VI. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE A BROKER'S ASSURANCE THAT IN COMPLIANCE WITH TITLE VI AND THE IMPLEMENTING REGULATIONS, NO PERSON SHALL BE EXCLUDED FROM PARTICIPATION IN, DENIED THE BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN ITS PROGRAMS AND ACTIVITIES ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. ADDITIONAL DHHS GUIDANCE IS LOCATED AT 68 FR 47311-02.

EOHHS RESERVES ITS RIGHT TO AT ANY TIME REVIEW SERVICE BROKER TO ASSURE THAT THEY ARE COMPLYING WITH THESE REQUIREMENTS. FURTHER, EOHHS RESERVES ITS RIGHT TO AT ANY TIME REQUIRE FROM SERVICE PROVIDER'S BROKERS, SUB-BROKERS AND BROKERS THAT THEY ARE ALSO COMPLYING WITH TITLE VI.

THE BROKER SHALL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH TITLE VI. AN ELECTRONIC COPY OF THE SERVICE PROVIDERS WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

THE BROKER'S WRITTEN COMPLIANCE PLAN MUST ADDRESS THE FOLLOWING REQUIREMENTS:

- WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL TITLE VI STANDARDS.

- DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE SERVICE PROVIDER'S SENIOR MANAGEMENT.

- EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.

- ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.

- PROVISION FOR INTERNAL MONITORING AND AUDITING.

- WRITTEN COMPLAINT PROCEDURES

- PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.

- PROVISION THAT ALL BROKERS, SUB-BROKERS AND BROKERS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID BROKERS, SUB-BROKERS AND BROKERS ARE IN COMPLAINCE WITH TITLE VI.

THE BROKER MUST ENTER INTO AN AGREEMENT WITH EACH BROKER, SUB-BROKER OR BROKER UNDER WHICH THERE IS THE PROVISION TO FURNISH TO IT, DHHS OR EOHHS ON REQUEST FULL AND COMPLETE INFORMATION RELATED TO TITLE VI COMPLIANCE.

THE BROKER MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAYS OF THE DATE OF A REQUEST BY DHHS OR EOHHS, FULL AND COMPLETE INFORMATION ON TITLE VI COMPLAINCE BY THE BROKER AND/OR ANY BROKER, SUB-BROKER OR BROKER OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH BROKER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE TITLE VI REGULATIONS. A COPY OF THE REGULATIONS IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER, **RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES/DEPARTMENT OF HUMAN SERVICES,** 57 HOWARD AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER: (401) 462-2130.
THE REGULATIONS ADDRESS THE FOLLOWING TOPICS:

SECTION:
80.1 PURPOSE
80.2 APPLICATION OF THIS REGULATION
80.3 DISCRIMINATION PROHIBITED
80.4 ASSURANCES REQUIRED
80.5 ILLUSTRATIVE APPLICATIONS
80.6 COMPLIANCE INFORMATION
80.7 CONDUCT OF INVESTIGATIONS
80.8 PROCEDURE FOR EFFECTING COMPLIANCE
80.9 HEARINGS
80.10 DECISIONS AND NOTICES
80.11 JUDICIAL REVIEW
80.12 EFFECT ON OTHER REGULATIONS; FORMS AND INSTRUCTIONS
80.13 DEFINITION

ADDENDUM III

NOTICE TO EOHHS' BROKERS OF THEIR RESPONSIBILITIES UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973

PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS, INSTITUTIONS, AND PERSONS THAT RECEIVE FEDERAL FINANCIAL ASSISTANCE THROUGH EOHHS ARE SUBJECT TO THE PROVISIONS OF SECTION 504 OF THE REHABILITATION ACT OF 1973 AND THE IMPLEMENTING REGULATIONS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH ARE LOCATED AT 45 CFR, PART 84 HERINAFTER COLLECTIVELY REFERRED TO AS SECTION 504. EOHHS CONTRACTS WITH SERVICE PROVIDERS INCLUDE THE PROVIDER'S ASSURANCE THAT IT WILL COMPLY WITH SECTION 504 OF THE REGULATIONS, WHICH PROHIBITS DISCRIMINATION AGAINST HANDICAPPED PERSONS IN PROVIDING HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS.

THE BROKER SHALL HAVE POLICIES AND PROCEDURES IN EFFECT, INCLUDING, A MANDATORY WRITTEN COMPLIANCE PLAN, WHICH ARE DESIGNED TO ASSURE COMPLIANCE WITH SECTION 504. AN ELECTRONIC COPY OF THE BROKER'S WRITTEN COMPLIANCE PLAN AND ALL RELEVANT POLICIES, PROCEDURES, WORKFLOWS AND RELEVANT CHART OF RESPONSIBLE PERSONNEL MUST BE SUBMITTED TO RHODE ISLAND EOHHS UPON REQUEST.

- THE CONTRACTOR'S WRITTEN COMPLIANCE PLAN MUST ADDRESS THE FOLLOWING REQUIREMENTS:

- WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT THAT ARTICULATE THE ORGANIZATION'S COMMITMENT TO COMPLY WITH ALL SECTION 504 STANDARDS.

- DESIGNATION OF A COMPLIANCE OFFICER WHO IS ACCOUNTABLE TO THE BROKER'S SENIOR MANAGEMENT.

- EFFECTIVE TRAINING AND EDUCATION FOR THE COMPLIANCE OFFICER AND THE ORGANIZATION'S EMPLOYEES.

- ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES.

- PROVISION FOR INTERNAL MONITORING AND AUDITING.

- WRITTEN COMPLAINT PROCEDURES

- PROVISION FOR PROMPT RESPONSE TO ALL COMPLAINTS, DETECTED OFFENSES OR LAPSES, AND FOR DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION INITIATIVES.

- PROVISION THAT ALL BROKERS, SUB-BROKERS AND BROKERS OF THE SERVICE PROVIDER EXECUTE ASSURANCES THAT SAID BROKERS, SUB-BROKERS AND BROKERS ARE IN COMPLAINCE WITH SECTION 504.

THE BROKER MUST ENTER INTO AN AGREEMENT WITH EACH BROKER, SUB-BROKER OR BROKER UNDER WHICH THERE IS THE PROVISION TO FURNISH TO THE BROKER, DHHS, DHS OR TO EOHHS ON REQUEST FULL AND COMPLETE INFORMATION RELATED TO SECTION 504 COMPLIANCE.

THE SERVICE PROVIDER MUST SUBMIT, WITHIN THIRTY-FIVE (35) DAYS OF THE DATE OF A REQUEST BY DHHS, EOHHS OR DHS, FULL AND COMPLETE INFORMATION ON SECTION 504 COMPLAINCE BY THE SERVICE PROVIDER AND/OR ANY BROKER, SUB-BROKER OR BROKER OF THE SERVICE PROVIDER.

IT IS THE RESPONSIBILITY OF EACH SERVICE PROVIDER TO ACQUAINT ITSELF WITH ALL OF THE PROVISIONS OF THE SECTION 504 REGULATIONS. A COPY OF THE REGULATIONS, TOGETHER WITH AN AUGUST 14, 1978 POLICY INTERPRETATION OF GENERAL INTEREST TO PROVIDERS OF HEALTH, WELFARE, OR OTHER SOCIAL SERVICES OR BENEFITS, IS AVAILABLE UPON REQUEST FROM THE COMMUNITY RELATIONS LIAISON OFFICER,**RI EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES,** 57 HOWARD AVENUE, CRANSTON, RI 02920; TELEPHONE NUMBER (401) 462-2130.

BROKERS SHOULD PAY PARTICULAR ATTENTION TO SUBPARTS A, B, C, AND F OF THE REGULATIONS WHICH PERTAIN TO THE FOLLOWING:

SUBPART A - GENERAL PROVISIONS

SECTION:

84.1	PURPOSE
84.2	APPLICATIONS
84.3	DEFINITIONS

84.4	DISCRIMINATION P R O H I B I T E D
84.5	ASSURANCE REQUIRED
84.6	REMEDIAL ACTION, VOLUNTARY ACTION, AND SELF-EVALUATION
84.7	DESIGNATION OF RESPONSIBLE EMPLOYEE AND ADOPTIVE GRIEVANCE PROCEDURES
84.8	NOTICE
84.9	ADMINISTRATIVE REQUIREMENTS FOR SMALL RECIPIENTS
84.10	EFFECT OF STATE OR LOCAL LAW OR OTHER REQUIREMENTS AND EFFECT OF EMPLOYMENT OPPORTUNITIES

SUBPART B - EMPLOYMENT PRACTICES

SECTION:

84.11	DISCRIMINATION PROHIBITED
84.12	REASONABLE ACCOMMODATION
84.13	EMPLOYMENT CRITERIA
84.14	PREEMPLOYMENT INQUIRIES
84.15-84.20	(RESERVED)

SUBPART C - PROGRAM ACCESSIBILITY

SECTION:

84.21	DISCRJMINATION PROHIBITED
84.22	EXISTING FACILITIES
84.23	NEW CONSTRUCTION
84.24.-84.30	(RESERVED)

SUBPART F - HEALTH, WELFARE, AND SOCIAL SERVICES

SECTION:

84.51	APPLICATION OF THIS SUBPART
84.52	HEALTH, WELFARE, AND OTHER SOCIAL SERVICES
84.53	DRUG AND ALCOHOL ADDICTS
84.54	EDUCATION AND INSTITUTIONALIZED PERSONS

ADDENDUM IV

DRUG FREE WORKPLACE POLICY

DRUG USE AND ABUSE AT THE WORKPLACE OR WHILE ON DUTY ARE SUBJECTS OF IMMEDIATE CONCERN IN OUR SOCIETY. THESE PROBLEMS ARE EXTREMELY COMPLEX AND ONES FOR WHICH THERE ARE NO EASY SOLUTIONS. FROM A SAFETY PERSPECTIVE, THE USERS OF DRUGS MAY IMPAIR THE WELL-BEING OF ALL EMPLOYEES, THE PUBLIC AT LARGE, AND RESULT IN DAMAGE TO PROPERTY. THEREFORE, IT IS THE POLICY OF THE STATE THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE IS PROHIBITED IN THE WORKPLACE. ANY EMPLOYEE(S) VIOLATING THIS POLICY WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. AN EMPLOYEE MAY ALSO BE DISCHARGED OR OTHERWISE DISCIPLINED FOR A CONVICTION INVOLVING ILLICIT DRUG BEHAVIOR, REGARDLESS OF WHETHER THE EMPLOYEES CONDUCT WAS DETECTED WITHIN EMPLOYMENT HOURS OR WHETHER HIS/HER ACTIONS WERE CONNECTED IN ANY WAY WITH HIS OR HER EMPLOYMENT. THE SPECIFICS OF THIS POLICY ARE AS FOLLOWS:

1. ANY UNAUTHORIZED EMPLOYEE WHO GIVES OR IN ANY WAY TRANSFERS A CONTROLLED SUBSTANCE TO ANOTHER PERSON OR SELLS OR MANUFACTURES A CONTROLLED SUBSTANCE WHILE ON DUTY, REGARDLESS OF WHETHER THE EMPLOYEE IS ON OR OFF THE PREMISES OF THE EMPLOYER WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION.

2. THE TERM “CONTROLLED SUBSTANCE” MEANS ANY DRUGS LISTED IN 21 USC, SECTION 812 AND OTHER FEDERAL REGULATIONS. GENERALLY, ALL ILLEGAL DRUGS AND SUBSTANCES ARE INCLUDED, SUCH AS MARIJUANA, HEROIN, MORPHINE, COCAINE, CODEINE OR OPIUM ADDITIVES, LSD, DMT, STP, AMPHETAMINES, METHAMPHETAMINES, AND BARBITURATES.

3. EACH EMPLOYEE IS REQUIRED BY LAW TO INFORM THE AGENCY WITHIN FIVE (5) DAYS AFTER HE/SHE IS CONVICTED FOR VIOLATION OF ANY FEDERAL OR STATE CRIMINAL DRUG STATUTE. A CONVICTION MEANS A FINDING OF GUILT (INCLUDING A PLEA OF NOLO CONTENDERE) OR THE IMPOSITION OF A SENTENCE BY A JUDGE OR JURY IN ANY FEDERAL OR STATE COURT.

4. THE EMPLOYER (THE HIRING AUTHORITY) WILL BE RESPONSIBLE FOR REPORTING CONVICTION(S) TO THE APPROPRIATE FEDERAL GRANTING SOURCE WITHIN TEN (10) DAYS AFTER RECEIVING NOTICE FROM THE EMPLOYEE OR OTHERWISE RECEIVES ACTUAL NOTICE OF SUCH CONVICTION(S). ALL CONVICTION(S) MUST BE REPORTED IN WRITING TO THE OFFICE OF PERSONNEL ADMINISTRATION (OPA) WITHIN THE SAME TIME FRAME.

5. IF AN EMPLOYEE IS CONVICTED OF VIOLATING ANY CRIMINAL DRUG STATUTE WHILE ON DUTY, HE/SHE WILL BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION. CONVICTION(S) WHILE OFF DUTY MAY RESULT IN DISCIPLINE OR DISCHARGE.

6. THE STATE ENCOURAGES ANY EMPLOYEE WITH A DRUG ABUSE PROBLEM TO SEEK ASSISTANCE FROM THE RHODE ISLAND EMPLOYEE ASSISTANCE PROGRAM (RIEAP). YOUR DEPARTMENT PERSONNEL OFFICER HAS MORE INFORMATION ON RIEAP.

7. THE LAW REQUIRES ALL EMPLOYEES TO ABIDE BY THIS POLICY.

EMPLOYEE RETAIN THIS COPY

ADDENDUM V

DRUG-FREE WORKPLACE POLICY PROVIDER CERTIFICATE OF COMPLIANCE

I,_____**, CHIEF EXECUTIVE OFFICER, TRANSPORTAION BROKER**_____, A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE STATE'S POLICY REGARDING THE MAINTENANCE OF A **DRUG-FREE WORKPLACE**. I HAVE BEEN INFORMED THAT THE UNLAWFUL MANUFACTURE, DISTRIBUTION, DISPENSATION, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE DEFINED IN ADDENDUM IV (TO INCLUDE BUT NOT LIMITED TO SUCH DRUGS AS MARIJUANA, HEROIN, COCAINE, PCP, AND CRACK, AND SUCH DRUGS AS IDENTIFIED IN ADDENDUM IV AND MAY ALSO INCLUDE LEGAL DRUGS WHICH MAY BE PRESCRIBED BY A LICENSED PHYSICIAN IF THEY ARE ABUSED), IS PROHIBITED ON THE STATE'S PREMISES OR WHILE CONDUCTING STATE BUSINESS. I ACKNOWLEDGE THAT MY EMPLOYEES MUST REPORT FOR WORK IN A FIT CONDITION TO PERFORM THEIR DUTIES.

AS A CONDITION FOR CONTRACTING WITH THE STATE, AS A RESULT OF THE FEDERAL OMNIBUS DRUG ACT, I WILL REQUIRE MY EMPLOYEES TO ABIDE BY THE STATE'S POLICY. FURTHER, I RECOGNIZE THAT ANY VIOLATION OF THIS POLICY MAY RESULT IN TERMINATION OF THE CONTRACT.

SIGNATURE:

_____

TITLE:

_____

DATE:

_____

ADDENDUM VI

SUB BROKER COMPLIANCE

I,**_____, CHIEF EXECUTIVE OFFICER, TRANSPORTATION BROKER _____,** A PROVIDER DOING BUSINESS WITH THE STATE OF RHODE ISLAND, HEREBY CERTIFY THAT ALL APPROVED SUB BROKERS PERFORMING SERVICES UNDER THE TERMS OF THIS AGREEMENT WILL HAVE EXECUTED WRITTEN CONTRACTS WITH THIS AGENCY, AND ALL CONTRACTS WILL BE MAINTAINED ON FILE AND PRODUCED UPON REQUEST. ALL CONTRACTS MUST CONTAIN LANGUAGE IDENTICAL TO THE PROVISIONS OF THIS AGREEMENT AS FOLLOWS:

SECTION 3.05.07 HOLD HARMLESS

SECTION 3.05.08 INSURANCE REQUIREMENT

SECTION 3.06.01 EMPLOYMENT PRACTICES

ADDENDUM II NOTICE TO RI'S EXECUTIVE OFFICE OF HEATLH AND HUMAN SERVICES'/RHODE ISLAND DEPARTMENT OF HUMAN SERVICES NOTICE TO DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITY UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

ADDENDUM III NOTICE TO RI'S EXECUTIVE OFFICE OF HEATLH AND HUMAN SERVICES' /RHODE ISLAND DEPARTMENT OF HUMAN SERVICES NOTICE OF THE DEPARTMENT OF HUMAN SERVICES SERVICE PROVIDERS OF THEIR RESPONSIBILITY UNDER SECTION USC 504 OF THE REHABILITATION ACT OF 1973

_____ _____

AUTHORIZED AGENT/PROVIDER SIGNATURE **DATE**

ADDENDUM VII

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

PUBLIC LAW 103-227, PART C - ENVIRONMENTAL TOBACCO SMOKE, ALSO KNOWN AS THE PRO-CHILDREN ACT OF 1994 **(ACT),** REQUIRES THAT SMOKING NOT BE PERMITTED IN ANY PORTION OF ANY INDOOR FACILITY OWNED OR LEASED OR CONTRACTED FOR BY AN ENTITY AND USED ROUTINELY OR REGULARLY FOR THE PROVISION OF HEALTH, DAY CARE, EDUCATION, OR LIBRARY SERVICES TO CHILDREN UNDER THE AGE OF 18, IF THE SERVICES ARE FUNDED BY FEDERAL PROGRAMS EITHER DIRECTLY OR THROUGH STATE OR LOCAL GOVERNMENTS, BY FEDERAL GRANT, CONTRACT, LOAN, OR LOAN GUARANTEE. THE LAW DOES NOT APPLY TO CHILDREN'S SERVICES PROVIDED IN PRIVATE RESIDENCES, FACILITIES FUNDED SOLELY BY MEDICARE OR MEDICAID FUNDS, AND PORTIONS OF FACILITIES USED FOR INPATIENT DRUG OR ALCOHOL TREATMENT. FAILURE TO COMPLY WITH THE PROVISIONS OF THE LAW MAY RESULT IN THE IMPOSITION OF A CIVIL MONETARY PENALTY OF UP TO $1000 PER DAY AND/OR THE IMPOSITION OF AN ADMINISTRATIVE COMPLIANCE ORDER ON THE RESPONSIBLE ENTITY.

BY SIGNING AND SUBMITTING THIS APPLICATION THE APPLICANT/GRANTEE CERTIFIES THAT IT WILL COMPLY WITH THE REQUIREMENTS OF THE **ACT.** THE APPLICANT/GRANTEE FURTHER AGREES THAT IT WILL REQUIRE THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN ANY SUBAWARDS WHICH CONTAIN PROVISIONS FOR CHILDREN'S SERVICES AND THAT ALL SUBGRANTEES SHALL CERTIFY ACCORDINGLY.

_____ _____

AUTHORIZED AGENT/PROVIDER SIGNATURE **DATE**

ADDENDUM VIII

INSTRUCTIONS FOR CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS PRIMARY COVERED TRANSACTIONS

BY SIGNING AND SUBMITTING THIS CONTRACT, THE PROSPECTIVE PRIMARY PARTICIPANT IS PROVIDING THE CERTIFICATION SET OUT BELOW.

THE INABILITY OF A PERSON TO PROVIDE THE CERTIFICATION REQUIRED BELOW WILL NOT NECESSARILY RESULT IN DENIAL OF PARTICIPATION IN THIS COVERED TRANSACTION. IF NECESSARY, THE PROSPECTIVE PARTICIPANT SHALL SUBMIT AN EXPLANATION OF WHY IT CANNOT PROVIDE THE CERTIFICATION. THE CERTIFICATION OR EXPLANATION WILL BE CONSIDERED IN CONNECTION WITH THE DEPARTMENT'S DETERMINATION WHETHER TO ENTER INTO THIS TRANSACTION. HOWEVER, FAILURE OF THE PROSPECTIVE PRIMARY PARTICIPANT TO FURNISH A CERTIFICATION OR EXPLANATION SHALL DISQUALIFY SUCH PERSON FROM PARTICIPATION IN THIS TRANSACTION.

THE CERTIFICATION IN THIS ADDENDUM IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THE DEPARTMENT DETERMINED THAT THE PROSPECTIVE PRIMARY PARTICIPANT KNOWINGLY RENDERED AN ERRONEOUS CERTIFICATION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE DEPARTMENT. THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OR DEFAULT.

THE PROSPECTIVE PRIMARY PARTICIPANT SHALL PROVIDE IMMEDIATE WRITTEN NOTICE TO THE DEPARTMENT IF AT ANY TIME THE PROSPECTIVE PRIMARY PARTICIPANT LEARNS THAT ITS CERTIFICATION WAS ERRONEOUS WHEN SUBMITTED OR HAS BECOME ERRONEOUS BY REASON OF CHANGED CIRCUMSTANCES.

THE TERMS "COVERED TRANSACTION," "DEBARRED," "SUSPENDED," "INELIGIBLE," "LOWER TIER COVERED TRANSACTION," "PARTICIPANT," "PERSON," "PRIMARY COVERED TRANSACTION," "PRINCIPAL," "PROPOSAL," AND "VOLUNTARILY EXCLUDED," AS USED IN THIS CLAUSE, HAVE THE MEANINGS SET OUT IN THE DEFINITIONS AND COVERAGE SECTIONS OF THE RULES IMPLEMENTING EXECUTIVE ORDER 12549: 45 CFR PART 76.

THE PROSPECTIVE PRIMARY PARTICIPANT AGREES BY SUBMITTING THIS CONTRACT THAT, SHOULD THE PROPOSED COVERED TRANSACTION BE ENTERED INTO, IT SHALL NOT KNOWINGLY ENTER INTO ANY LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS DEBARRED, SUSPENDED, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS COVERED TRANSACTION, UNLESS AUTHORIZED BY THE EXECUTIVE OFFICE.

THE PROSPECTIVE PRIMARY PARTICIPANT FURTHER AGREES BY SUBMITTING THIS CONTRACT THAT IT WILL INCLUDE THE CLAUSE TITLED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS, PROVIDED BY EOHHS, WITHOUT MODIFICATION, IN ALL LOWER TIER COVERED TRANSACTIONS AND IN ALL SOLICITATIONS FOR LOWER TIER COVERED TRANSACTIONS.

A PARTICIPANT IN A COVERED TRANSACTION MAY RELY UPON A CERTIFICATION OF A PROSPECTIVE PARTICIPANT IN A LOWER TIER COVERED TRANSACTION THAT IS NOT DEBARRED, SUSPENDED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM THE COVERED TRANSACTION, UNLESS IT KNOWS THAT THE CERTIFICATION IS ERRONEOUS. A PARTICIPANT MAY DECIDE THE METHOD AND FREQUENCY BY WHICH IT DETERMINES THE ELIGIBILITY OF ITS PRINCIPALS. EACH PARTICIPANT MAY, BUT IS NOT REQUIRED TO, CHECK THE NONPROCUREMENT LIST (OF EXCLUDED PARTIES).

NOTHING CONTAINED IN THE FOREGOING SHALL BE CONSTRUED TO REQUIRE ESTABLISHMENT OF A SYSTEM OF RECORDS IN ORDER TO RENDER IN GOOD FAITH THE CERTIFICATION REQUIRED BY THIS CLAUSE. THE KNOWLEDGE AND INFORMATION OF A PARTICIPANT IS NOT REQUIRED TO EXCEED THAT WHICH IS NORMALLY POSSESSED BY A PRUDENT PERSON IN THE ORDINARY COURSE OF BUSINESS DEALINGS.

EXCEPT FOR TRANSACTIONS AUTHORIZED UNDER PARAGRAPH 6 OF THESE INSTRUCTIONS, IF A PARTICIPANT IN A COVERED TRANSACTION KNOWINGLY ENTERS INTO A LOWER TIER COVERED TRANSACTION WITH A PERSON WHO IS SUSPENDED, DEBARRED, INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM PARTICIPATION IN THIS TRANSACTION, IN ADDITION TO OTHER REMEDIES AVAILABLE TO THE FEDERAL GOVERNMENT, THE DEPARTMENT MAY TERMINATE THIS TRANSACTION FOR CAUSE OF DEFAULT.

ADDENDUM IX

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS

THE BROKER, AS THE PRIMARY PARTICIPANT, CERTIFIES TO THE BEST OF THE BROKER'S KNOWLEDGE AND BELIEF, THAT THE BROKER AND ITS PRINCIPALS:

1. ARE NOT PRESENTLY DEBARRED, SUSPENDED, PROPOSED FOR DEBARMENT, DECLARED INELIGIBLE, OR VOLUNTARILY EXCLUDED FROM COVERED TRANSACTIONS BY ANY FEDERAL DEPARTMENT OR AGENCY;

2. HAVE NOT WITHIN A THREE (3) YEAR PERIOD PRECEDING THIS CONTRACT BEEN CONVICTED OF OR HAD A CIVIL JUDGMENT RENDERED AGAINST THEM FOR COMMISSION OF FRAUD OR A CRIMINAL OFFENSE IN CONNECTION WITH OBTAINING, ATTEMPTING TO OBTAIN, OR PERFORMING A PUBLIC (FEDERAL, STATE OR LOCAL) TRANSACTION OR CONTRACT UNDER PUBLIC TRANSACTION; VIOLATION OF FEDERAL OR STATE ANTITRUST STATUES OR COMMISSION OF EMBEZZLEMENT, THEFT, FORGERY, BRIBERY, FALSIFICATION OR DESTRUCTION OF RECORDS, MAKING FALSE STATEMENTS, OR RECEIVING STOLEN PROPERTY;

3. ARE NOT PRESENTLY INDICTED OR OTHERWISE CRIMINALLY OR CIVILLY CHARGED BY A GOVERNMENTAL ENTITY (FEDERAL, STATE OR LOCAL) WITH COMMISSION OF ANY OF THE OFFENSES ENUMERATED IN PARAGRAPH (1) AND (2) OF THIS ADDENDUM; AND

4. HAVE NOT WITHIN A THREE-YEAR PERIOD PRECEDING THIS CONTRACT HAD ONE OR MORE PUBLIC TRANSACTIONS (FEDERAL, STATE OR LOCAL) TERMINATED FOR CAUSE OR DEFAULT.

WHERE THE PROSPECTIVE PRIMARY PARTICIPANT IS UNABLE TO CERTIFY TO ANY OF THE STATEMENTS IN THIS CERTIFICATION, SUCH PROSPECTIVE PRIMARY PARTICIPANT SHALL ATTACH AN EXPLANATION TO THIS CONTRACT.

AUTHORIZED AGENT/PROVIDERSIGNATURE **DATE**

ADDENDUM X

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS, AND COOPERATIVE AGREEMENTS

THE UNDERSIGNED CERTIFIES, TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, THAT:

1. NO FEDERAL APPROPRIATED FUNDS HAVE BEEN PAID OR WILL BE PAID, BY OR ON BEHALF OF THE UNDERSIGNED, TO ANY PERSON FOR INFLUENCING OR ATTEMPTING TO INFLUENCE AN OFFICER OR EMPLOYEE OF AN AGENCY, A RECIPIENT OF CONGRESS, AN OFFICER OR EMPLOYEE OF CONGRESS, OR AN EMPLOYEE OF A RECIPIENT OF CONGRESS IN CONNECTION WITH THE AWARDING OF ANY FEDERAL CONTRACT, THE MAKING OF ANY FEDERAL GRANT, THE MAKING OF ANY FEDERAL LOAN, THE ENTERING INTO OF ANY COOPERATIVE AGREEMENT, AND THE EXTENSION, CONTINUATION, RENEWAL, AMENDMENT, OR MODIFICATION OF ANY FEDERAL CONTRACT, GRANT, LOAN OR COOPERATIVE AGREEMENT.

2. IF ANY FUNDS OTHER THAN FEDERAL APPROPRIATED FUNDS HAVE BEEN PAID OR WILL BE PAID TO ANY PERSON FOR INFLUENCING OR ATTEMPTING TO INFLUENCE AN OFFICER OR EMPLOYEE OF ANY AGENCY, A RECIPIENT OF CONGRESS, AN OFFICER OF EMPLOYEE OF CONGRESS, OR AN EMPLOYEE OF A RECIPIENT OF CONGRESS IN CONNECTION WITH THIS FEDERAL CONTRACT, GRANT, LOAN, OR COOPERATIVE AGREEMENT, THE UNDERSIGNED SHALL COMPLETE AND SUBMIT STANDARD FORM-LLL, A DISCLOSURE FORM TO REPORT LOBBYING IN ACCORDANCE WITH ITS INSTRUCTIONS.

3. THE UNDERSIGNED SHALL REQUIRE THAT THE LANGUAGE OF THIS CERTIFICATION BE INCLUDED IN THE AWARD DOCUMENTS FOR ALL SUBAWARDS AT ALL TIERS (INCLUDING SUBCONTRACTS, SUBGRANTS, AND CONTRACTS UNDER GRANTS, LOANS AND COOPERATIVE AGREEMENTS) AND THAT ALL SUBRECIPIENTS SHALL CERTIFY AND DISCLOSE ACCORDINGLY.

THIS CERTIFICATION IS A MATERIAL REPRESENTATION OF FACT UPON WHICH RELIANCE WAS PLACED WHEN THIS TRANSACTION WAS MADE OR ENTERED INTO. SUBMISSION OF THIS CERTIFICATION IS A PREREQUISITE FOR MAKING OR ENTERING INTO THIS TRANSACTION IMPOSED BY SECTION 1352, TITLE 31, UNITED STATES CODE; AND THE FINAL IMPLEMENTING REGULATIONS PUBLISHED IN THE

FEDERAL REGISTER**,** FEBRUARY 26, 1990, VOLUME 55, NO. 38, PAGES 6735-6756, ENTITLED NEW RESTRICTIONS ON LOBBYING; INTERIM FINAL RULE. ANY PERSON WHO FAILS TO FILE THE REQUIRED CERTIFICATION SHALL BE SUBJECT TO A CIVIL PENALTY OF NOT LESS THAN $10,000 AND NOT MORE THAN $100,000 FOR EACH SUCH FAILURE.

IF ANY NON-FEDERAL OR STATE FUNDS HAVE BEEN OR WILL BE PAID TO ANY PERSON IN CONNECTION WITH ANY OF THE COVERED ACTIONS IN THIS PROVISION, THE BROKER SHALL COMPLETE AND SUBMIT A "DISCLOSURE OF LOBBYING ACTIVITIES" FORM.

THE BROKER MUST CERTIFY COMPLIANCE WITH ALL TERMS OF THE BYRD ANTI-LOBBYING AMENDEMENT (31 U.S.C 1352) AS PUBLISHED IN THE FEDERAL REGISTER MAY 27, 2003, VOLUME 68, NUMBER 101.

THE BROKER HEREBY CERTIFIES THAT IT WILL COMPLY WITH BYRD ANTI-LOBBYING AMENDMENT PROVISIONS AS DEFINED IN 45 CFR PART 93 AND AS AMENDED FROM TIME TO TIME.

FINAL RULE REQUIREMENTS CAN BE FOUND AT:

http://www.socialsecurity.gov/oag/grants/20cfr438.pdf
https://www.socialsecurity.gov/OP_Home/cfr20/435/435-ap01.htm

SIGNATURE: _____

TITLE: _____

DATE: _____

ADDENDUM XI

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS SUPPLEMENTAL TERMS AND CONDITIONS FOR CONTRACTS AND SUBAWARDS FUNDED IN WHOLE OR IN PART BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, PUB. L. NO. 111-5

1. Definitions

a. "ARRA" or "Recovery Act" means the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat.115.

b. "ARRA Funds" means any funds that are expended or obligated from appropriations made under ARRA.

c. "ARRA Requirements" means these Supplemental Terms and Conditions, as well as any terms and conditions required by: ARRA; federal law, regulation, policy or guidance; the federal Office of Management and Budget (OMB); the awarding federal agency; or, the Rhode Island Office of Economic Recovery and Reinvestment (OERR).

d. "Contract" means the contract to which these Supplemental Terms and Conditions are attached, and includes an agreement made pursuant to a grant or loan sub award to a Sub-Recipient.

e. "Broker" means the party or parties to the Contract other than the Prime Recipient and includes a sub grantee or a borrower. For the purposes of ARRA reporting, Broker is either a Sub-Recipient or a Recipient Broker under this Contract.

f. "Prime Recipient" means a non-Federal entity that expends Federal awards received directly from a Federal awarding agency to carry out a Federal program.

g. "Recipient Broker" means a Broker that receives ARRA Funds from a Prime Recipient.

h. “Sub broker” means any entity engaged by Broker to provide goods or perform services in connection with this contract.

i. "Sub-Recipient Broker" means a Broker that receives ARRA Funds from a Sub-Recipient.

j. "Sub-Recipient" means a non-Federal entity receiving ARRA Funds through a Prime Recipient to carry out an ARRA funded program or project, but does not include an individual that is a beneficiary of such a program. The term "Sub-Recipient" is intended to be consistent with the definition in OMB Circular A-133 and section 2.2 of the June 22, 2009 OMB Reporting Guidance.1 A Sub-Recipient is sometimes referred to as a sub grantee.

k. "Supplemental Terms and Conditions" means these Supplemental Terms and Conditions for Contracts and Sub Awards Funded in Whole or in Part by The American Reinvestment

Recovery Act of 2009, Pub. L. No. 111-5, as may be subsequently revised pursuant to ongoing guidance from the relevant federal or State authorities.

l. "Broker" means a dealer, distributor, merchant, or other seller providing goods or services that are required for the project or program funded by ARRA. The term "Broker" is intended to be consistent with the definition in OMB Circular A-133 and section 2.2 of the June 22, 2009 OMB Reporting Guidance. Implementing Guidance for the Reports on Use of Funds Pursuant to the American Recovery and Reinvestment Act of 2009, M-09-21 (June 22, 2009), available at http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-21.pdf.

2. General

a. To the extent this Contract involves the use of ARRA Funds, Broker shall comply with both the ARRA Requirements and these Supplemental Terms and Conditions, except where such compliance is exempted or prohibited by law.

b. The Broker acknowledges these Supplemental Terms and Conditions may require changes due to future revisions of or additions to the ARRA requirements, and agrees that any revisions of or additions to the ARRA requirements shall automatically become a part of the Supplemental Terms and Conditions without the necessity of either party executing or issuing any further instrument and shall become a part of Broker's obligations under the Contract. The State of Rhode Island may provide written notification to Broker of such revisions, but such notice shall not be a condition precedent to the effectiveness of such revisions.

3. Conflicting Terms

Broker agrees that, to the extent that any term or condition herein conflicts with one or more ARRA Requirements, the ARRA Requirements shall control.

4. Enforceability

Broker agrees that if it or one of its sub brokers or sub-recipients fails to comply with all applicable federal and State requirements governing the use of ARRA funds, including any one of the terms and conditions specified herein, the State may withhold or suspend, in whole or in part, funds awarded under the program, recover misspent funds, or both. This provision is in addition to all other civil and criminal remedies available to the State under applicable state and federal laws and regulations.

5. Applicability to Subcontracts and Sub awards

Broker agrees that it shall include the Supplemental Terms and Conditions set forth herein, including this provision, in all subcontracts or sub awards made in connection with projects funded in whole or in part by ARRA, and also agrees that it will not include provisions in any such subcontracts or sub awards that conflict with either ARRA or the terms and conditions herein.

6. Availability of Funding

Broker understands that federal funds made available by ARRA are temporary in nature and agrees that the State is under no obligation to provide additional State financed appropriations once the temporary federal funds are expended.

7. Inspection and Audit of Records

Broker agrees that it shall permit the State and its representatives, the United States Comptroller General or his representative or the appropriate inspector general appointed under section 3 or 8G of the Inspector General Act of 1978 or his representative to:

i. Examine, inspect, copy, review or audit any records relevant to, and/or involve transactions relating to, this agreement, including documents and electronically stored information in its or any of its sub brokers' or sub recipients' possession, custody or control unless subject to a valid claim of privilege or otherwise legally protected from disclosure; and

ii. Interview any officer or employee of the Broker regarding the activities and programs funded by ARRA.

8. Registration Requirements

a. **DUNS Number Registration**. Broker agrees: (i) if it does not have a Dun and Bradstreet Data Universal Numbering System (DUNS) Number, to register for a DUNS Number within 10 business days of receiving this Contract; (ii) to provide the State with its DUNS number prior to accepting funds under this agreement; and (iii) to inform the State of any material changes concerning its DUNS number.

b. **Central Broker Registration**. To the extent that Broker is a Sub-Recipient, it agrees: (i) to maintain a current registration in the Central Broker Registration (CCR) at all times this agreement is in force, (ii) to provide the State with documentation sufficient to demonstrate that it has a current CCR registration, and (iii) to inform the State of any material changes concerning this registration.

c. **FederalReporting.gov Registration**. To the extent that Broker is a Sub - Recipient, it agrees: (i) to register on FederalReporting.gov within 10 business days of receiving this sub award; (ii) to maintain a current registration on FederalReporting.gov at all times this agreement is in force; (iii) to provide the State with documentation sufficient to demonstrate that it has a current registration on FederalReporting.gov, and (iv) to inform the State of any material changes concerning this registration.

9. Reporting Requirements under § 1512 of ARRA

a. Broker agrees to provide the State with data sufficient to fulfill the State's ARRA reporting requirements within the timeframes established by State or federal law, regulation or policy, including but not limited to section 1512 reporting requirements.

b. To the extent that Broker is a Sub-Recipient with a Sub award having a total value of greater than $25,000, it agrees to report directly to the Federal government the information described in section 1512(c) of ARRA using the reporting instructions and data elements available online at FederalReporting.gov and ensure that any information that is prefilled is corrected or updated as needed. Information from these reports will be made available to the public.

c. To the extent that Broker is a Sub-Recipient with a Sub award having a total value of greater than $25,000, it accepts delegation of reporting responsibility of FFATA data elements required under section 1512 of ARRA for payments from the State. Sub-Recipient shall utilize the federal government's online reporting solution at www.FederalReporting.gov. Reports are due no later than ten calendar days after each calendar quarter in which the recipient receives the assistance award funded in whole or in part by ARRA.

d. To the extent that Broker is a Sub-Recipient with a Sub award having an initial total value of less than $25,000, but is subsequently modified to exceed $25,000, Broker agrees that subsections (b) and (c) above apply after the modification.

10. Buy American Requirements under § 1605 of ARRA

a. Broker agrees that, in accordance with section 1605 of ARRA, it will not use ARRA funds for a project for the construction, alternation, maintenance, or repair of a public building or public work unless all of the iron, steel and manufactured goods used in the project are produced in the United States in a manner consistent with United States obligations under international agreements. In addition to the foregoing Broker agrees to abide by all regulations issued pursuant to section 1605 of ARRA.

b. Broker understands that this requirement may only be waived by the applicable federal agency in limited situations as set out in section 1605 of ARRA and federal regulations issued pursuant thereto.

11. Wage Rate Requirements under § 1606 of ARRA

a. Broker agrees that it will comply with the wage rate requirements contained in section 1606 of ARRA, which requires that, notwithstanding any other provision of law, all laborers and mechanics employed by brokers and sub brokers on projects funded

directly by or assisted in whole or in part by and through the Federal Government pursuant to ARRA shall be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the Secretary of Labor in accordance with subchapter IV of chapter 31 of title 40, United States Code. The Secretary of Labor's determination regarding the prevailing wages applicable in Rhode Island is available at http://www.gpo.gov/davisbacon/ri.html.

b. Broker agrees that it will comply with all federal regulations issued pursuant to section 1606 of ARRA, and that it will require any sub brokers or sub recipients to comply with the above provision.

12. Required Jobs Data Reporting under § 1512(c) (3) (D) of ARRA

a. Broker agrees, in accordance with section 1512(c)(3)(D) of ARRA and section 5 of the June 22, 2009 OMB Reporting Guidance (entitled "Reporting on Jobs Creation Estimates and by Recipients"), to provide an estimate of the number of jobs created and the number of jobs retained by ARRA-funded projects and activities. In order to perform the calculation, the Broker will provide the data elements listed in sub-section (b) below.

b. Broker agrees that, no later than two business days after the end of each calendar quarter, it will provide to the State the following data elements using a form specified by the State:

   i. The total number of ARRA-funded hours worked on this award.

   ii. The number of hours in a full-time schedule for a quarter.

   iii. A narrative description of the employment impact of the ARRA funded work. This narrative is cumulative for each calendar quarter and at a minimum, shall address the impact on the Broker's workforce and the impact on the workforces of its sub brokers or sub-recipients.

c. Broker agrees that, in the event that the federal government permits direct reporting of section 1512(c)(3)(D) jobs data by sub-recipients or brokers, it will directly report jobs data to the federal government, consistent with any applicable federal law, regulations and guidance.

13. Segregation of Funds

a. Broker agrees that it shall segregate obligations and expenditures of ARRA funds from other funding it receives from the State and other sources, including other Federal awards or grants.

b. Broker agrees that no part of funds made available under ARRA may be commingled with any other funds or used for a purpose other than that of making payments in support

of projects and activities expressly authorized by ARRA.

14. Disclosure pursuant to the False Claims Act

Broker agrees that it shall promptly refer to an appropriate Federal Inspector General any credible evidence that a principal, employee, agent, sub broker or other person has committed a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving ARRA funds.

15. Disclosure of Fraud, Waste and Mismanagement to State Authorities

Broker shall also refer promptly to the Rhode Island Department of Administration, Department of Purchases, any credible evidence that a principal, employee, agent, broker, sub grantee, sub broker, or other person has committed a criminal or civil violation of State or Federal laws and regulations in connection with funds appropriated under ARRA.

16. Prohibited Uses of ARRA Funds

a. Broker agrees that neither it nor any sub brokers or sub-recipients will use the funds made available under this agreement for any casinos or other gambling establishments, aquariums, zoos, golf courses, swimming pools, or similar projects.

b. Broker agrees that neither it nor any sub brokers or sub-recipients will use the funds made available under this agreement in a manner inconsistent with any certification made by the Governor or any other State official pursuant to the certification requirements of ARRA, which are published online at http://www.recovery.ri.gov/certification/.

17. Whistleblower Protection under §1553 of ARRA

a. Broker agrees that it shall not discharge, demote, or otherwise discriminate against an employee as a reprisal for disclosures by the employee of information that he or she reasonably believes is evidence of (1) gross mismanagement of an agency contract or grant relating to covered funds; (2) a gross waste of covered funds; (3) a substantial and specific danger to public health or safety related to the implementation or use of covered funds; (4) an abuse of authority related to the implementation or use of covered funds; or (5) a violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) or grant, awarded or issued relating to covered funds.

b. Broker agrees to post notice of the rights and remedies available to employees under section 1553 of ARRA.

18. ARRA Protections for Indians in Medicaid and CHIP

Under section 5006(d), all contracts with Medicaid and CHIP managed care entities, which include Medicaid and CHIP managed care organizations (MCOs) and PCCMs, must:

1. Permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;

2. Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian recipients who are eligible to receive services from such providers;

3. Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian recipients who are eligible to receive services from such providers either: (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

4. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45 and 42 CFR 447.46.

Please note that the State will strictly enforce compliance with all ARRA Requirements and these Supplemental Terms and Conditions. Accordingly, all Brokers should familiarize themselves with these Supplemental Terms and Conditions as well as all ARRA Requirements as they relate to this Contract.

ADDENDUM XII

BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Business Associate Agreement Addendum, XII**,** (hereinafter referred to as "Business Associate"), may use, access or disclose Protected Health Information to perform functions, activities or services for or on behalf of the State of Rhode Island, Department of Human Services (hereinafter referred to as the "Covered Entity"), as specified herein and the attached Agreement between the Business Associate and the Covered Entity (hereinafter referred to as "the Agreement"), which this addendum supplements and is made part of, provided such use, access, or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d et seq., and its implementing regulations including, but not limited to, 45 CFR, parts 160[lvi], 45 CFR, parts 162 and 45 CFR, parts 164, hereinafter referred to as the Privacy and Security Rules and patient confidentiality regulations, and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (HITECH Act) and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates, Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26, and Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5- 37.3-1 et seq. Business Associate recognizes and agrees itis obligated by law to meet the applicable provisions of the HITECH Act.

1. Definitions

A. "Addendum" means this Business Associate Agreement Addendum.

B. "Agreement" means the contractual Agreement by and between the State of Rhode Island, Department of Human Services and Business Associate, awarded pursuant to State of Rhode Island's Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and Rhode Island Department of Administration, Division of Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

C. "Breach" means the acquisition, access, use or disclosure of Protected Health Information (PHI) in a manner not permitted under HIPAA (45 CFR Part 164[xv], Subpart E) which compromises the security or privacy of the Protected Health Information. For the purposes of the HITECH Act, a Breach shall not include:

i. Any unintentional acquisition, access or use of PHI by a workforce recipient or person acting under the authority of the Covered Entity or the Business Associate, if such acquisition, access or use was made in good faith and within the course and

scope of authority and employment, and does not result in further use or disclosure in a meaner not permitted under the HIPPA Privacy Rule; or,

ii. Any inadvertent disclosure by a person who is authorized to access PHI at Covered Entity or Business Associate to another person authorized to access PHI at Covered Entity or Business Associate, respectively, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule; or,

iii. A disclosure of PHI where Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

D. "Business Associate" means with respect to a Covered Entity, a person who:

i. On behalf of such Covered Entity, but other than in the capacity of a recipient of the workforce of such Covered Entity performs or assists in the performance of:

a. a function or activity involving the use or disclosure of Personally Identifiable Health Information, including claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or,

b. any other function or activity regulated by the HIPAA Privacy or HIPAA Security Regulations;

ii. Provides, other than in the capacity of a recipient of the workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for such Covered Entity where the provision of the service involves the disclosure of Personally Identifiable Health Information from such Covered Entity to the person.

E. "Client/Patient" means Covered Entity funded person who is a recipient and/or the client or patient of the Business Associate.

F. "Covered Entity" means a health plan, a health care clearinghouse or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA Privacy and Security Regulations.

G. "Data Aggregation" means, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another Covered Entity, to permit data analyses that relate to the health care operations of the respective Covered Entities.

H. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff.

I. "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media as defined in the HIPA Security Regulations.

J. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

K. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information including, but not limited to, 45 CFR Part 160[liv] and 45 CFR Part 164[xv], Subpart A and Subpart E.

L. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations promulgated thereunder and as amended from time to time.

M. "Personally Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and:

i. is created or received by a health care provider, health plan, employer or health care clearinghouse; and,

ii. relates to the past, present or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and,

a. that identifies the individual; or

b. with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

N. "Protected Health Information" or "PHI" means Personally Identifiable Health Information transmitted or maintained in any form or medium that:

i. is received by Business Associate from Covered Entity;

ii. Business Associate creates for its own purposes from Personally Identifiable Health Information that Business Associate received from Covered Entity; or,

iii. is created, received, transmitted or maintained by Business Associate on behalf of Covered Entity.

Protected Health Information excludes Personally Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. Section 1232(g), records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv), and employment records held by the Covered Entity in its role as employer.

O. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under or pursuant to Section 13402 (h)(2) of the HITECH Act under ARRA.

P. "Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

Q. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160[lvi] and 45 CFR Part 162, and 45 CFR Part 164[xv], Subparts A and C. The application of Security provisions Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Business Associate of Covered Entity in the same manner that such sections apply to the Covered Entity.

R. "Suspected breach" is a suspected acquisition, access, use or disclosure of protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.

S. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

T. "Broker of Personal Health Records" shall mean an entity, other than a covered entity, that offers or maintains a personal health record.

U. Any terms capitalized, but not otherwise defined, in the Addendum shall have the same meaning as those terms have under HIPAA, the HIPAA Privacy Rule, the HIPAA Security Rule and the HITECH Act.

2. Obligations and Activities of Business Associate

A. Permitted Uses.

i. PHI Described. PHI disclosed by the Covered Entity to the Business Associate, PHI created by the Business Associate on behalf of the Covered Entity, and PHI received by the Business Associate from a third party on behalf of the Covered Entity are disclosable under this Addendum. The disclosable PHI is limited to the minimum necessary to complete the tasks, or to provide the services, associated with the terms of the original Agreement.

Purposes. Except as otherwise limited in this Addendum, Business Associate may use or disclose the PHI on behalf of, or to provide services to, Covered Entity for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Covered Entity or violate the minimum necessary and related Privacy and Security policies and procedures of the Covered Entity. Business Associate shall disclose to its employees, sub brokers, agents, or other third, parties, and request from Covered Entity, only the minimum PHI necessary to perform or fulfill a specific function required or permitted under the Agreement.

B. Prohibited Uses and Disclosures. Business Associate shall not use PHI in any manner that would constitute a violation of the HIPAA Privacy Rule or the HITECH Act.

i. Stated Purposes Only. The Business Associate shall not use the PHI for any purpose other than stated in the Agreement, this Addendum or as required or permitted by law.

ii. Limited Disclosure. The PHI is confidential and will not be disclosed by the Business Associate other than as stated in this Addendum or as required or permitted by law. Business Associate will refrain from receiving any remuneration in exchange for any individual's PHI, unless Covered Entity gives written approval, and the exchange is pursuant to a valid authorization (that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual), or satisfies one of the exceptions enumerated in Section 13405(e)(2) of the HITECH Act. Business Associate will refrain from marketing activities that would violate HIPAA, specifically Section 13406 of the HITECH Act. Business Associate will report to Covered Entity any use or disclosure of the PHI, including any Security Incident not provided for by this Addendum of which it becomes aware.

C. Appropriate Safeguards. Business Associate shall implement the following administrative, physical, and technical safeguards in accordance with the Security Rule under 45 C.F.R., Sections 164.308, 164.310, 164.312 and 164.316:

i. Implement policies and procedures to prevent, detect, contain and correct security violations; identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the Business Associate; implement a security awareness and training program for all recipients of its workforce; implement policies and procedures to prevent those workforce recipients who are not authorized to have access from obtaining access to electronic PHI; implement policy and procedures to address security incidents; establish policies and procedures for responding to an emergency or other occurrence that damages systems that contain electronic PHI; and perform a periodic technical and non-technical evaluation in response to environmental or operational changes affecting the security of electronic PHI that establishes the extent to which the security policies and procedures of Business Associate (and any business associate of Business Associate) meet the requirements of this subpart.

ii. Implement policies and procedures to limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed; implement policies and procedures that specify the proper functions to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstations that can access electronic PHI; implement physical safeguards for all workstations that access electronic PHI; restrict access to authorized users; implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic PHI into and out of a facility and the movement of these items within the facility.

iii. Implement technical policies and procedures for electronic information systems that maintain electronic PHI to allow access only to those persons or software programs that have been granted access rights as specified in 45 C.F.R., Section 164.208; implement hardware, software and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic PHI; implement policies and procedures to protect electronic PHI from improper alteration, destruction, unauthorized access or Joss of integrity or availability.

iv. The Business Associate will use appropriate safeguards to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to the limitation of the groups of its employees or agents, otherwise known as workforce recipients, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary.

v. Appropriate notification and training of its employees or agents to whom the PHI will be disclosed in order to protect the PHI from unauthorized disclosure. At the sole discretion of the Business Associate, provide a written statement to each employee or agent as to the necessity of maintaining the security and confidentiality of Protected Health Information, and of the penalties provided for the unauthorized release, use, or disclosure of this information. Receipt of the statement is to be acknowledged by the employee or agent, who is to sign and return the statement to his or her employer or principal, who then is to retain the signed original. The employee or agent is also to be furnished with a copy of the signed statement. The Business Associate shall take no disciplinary or punitive action against any employee or agent solely for bringing evidence of violation of the referenced security requirements to the attention of the Covered Entity.

vi. A copy of the above-described policies, procedures and documentation shall be provided to the Covered Entity within ten (10) days from the date of request of the Covered Entity.

D. Mitigation. Business Associate shall have procedures in place to mitigate, to the extent practical, any harmful effect that is known or reasonably foreseeable to the Business Associate of a use, access or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, and Business Associate shall report its mitigation activity to the Covered Entity.

E. Notification of Breach, Suspected Breach, Loss, or Potential Loss of Confidential data or PHI.

i. During the term of the Agreement and/or this Addendum, the Business Associate shall notify the Covered Entity within one (1) hour by telephone call plus e-mail, web form or fax upon the discovery of any Breach of security of PHI or Suspected Breach of security of PHI (where the use or disclosure is not provided for and permitted by this Addendum) of which it becomes aware. In the event of any suspected Security Incident, intrusion, unauthorized use or disclosure, loss, or potential loss of PHI, in violation of the Agreement and this Addendum, or potential loss of confidential data affecting the Agreement and this Addendum, the Business Associate shall notify the Covered Entity within twenty-four (24) hours by telephone call plus e-mail, web form or fax.

ii. The Business Associate shall immediately investigate such Security Incident(s), Breach, Suspected Breach, or unauthorized use or disclosure of PHI or confidential data. Within 48 hours of the discovery, the Business Associate shall notify the Covered Entity's contract manager, and the Office of Technology Service Desk of:

a. What data elements were involved and the extent of the data involved in the Breach;

b. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

c. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

d. A description of the probable causes of the improper use or disclosure; and,

e. Whether any federal or state laws requiring individual notifications of Breaches are triggered. Covered Entity will coordinate with Business Associate to determine additional specific actions that will be required of the Business Associate for mitigation of the Breach, suspected breach, unauthorized use or disclosure which may include, but is not limited to, notification to the individual, the media, HHS, or other authorities, as well as any other related notice requirements.

iii. Further, the Business Associate shall:

a. Conduct and document a risk assessment by investigating without reasonable delay and in no case later than twenty (20) calendar days of discovery of the potential Breach to determine the following:

1. Whether there has been an impermissible use, acquisition, access or disclosure of PHI under the Privacy Rule;
2. Whether an impermissible use or disclosure compromises the security or privacy of the PHI by posing a significant risk of financial, reputational or other harm to the Client/Patient; and,
3. Whether the incident falls under one of the Breach exceptions.

b. Provide completed risk assessment and investigation documentation to Covered Entity's Office of Compliance within twenty-five (25) calendar days of discovery of the potential breach with decision whether a Breach has occurred:

1. If a Breach has not occurred, notification to Client/Patient(s) is not required.
2. If a Breach has occurred, notification to the Client/Patient(s) is required, and Business Associate must provide Covered Entity with affected Client/Patient names and contact information so the Covered Entity can provide notification.

c. Make available to Covered Entity and governing State and Federal agencies

in a time and manner designated by Covered Entity or governing State and Federal agencies, any policies, procedures, internal practices and records relating to a potential breach for the purposes of audit or should the Covered Entity reserve the right to conduct its own investigation and analysis.

iv. All associated costs shall be borne by the Business Associate. This may include, but not be limited to costs associated with notifying the individuals or entities listed in section E. Depending on the nature and scope of the security incident, remedies may include, among other things, information to individuals on obtaining credit reports and notification to applicable credit card companies, notification to the local office of the secret service, and or affected users and other applicable parties, utilization of a call center and the offering of credit monitoring services on a selected basis. Business Associate agrees that the Covered Entity shall be held harmless in the event of such a breach and accepts fully the legal and financial responsibility associated with mitigating any harmful effects that may or have been caused, including but not limited to the Business Associate and Covered Entity's required actions pursuant to HIPAA and HITECH as defined herein. Business Associate agrees that it is subject to and shall ensure compliance with all HIPAA regulations in effect at the time of this Addendum and as shall be amended, under HIPAA, from time to time, and any and all reporting requirements required by HIPAA at the time of this Addendum and as shall be amended, under HIPAA, from time to time. As well as ensuring compliance with the Rhode Island Confidentiality of Health Care Information Act, Rhode Island General Laws, Sections 5-37.3 et seq.

v. Assistance in Litigation or Administrative Proceedings. The Business Associate shall make itself and any sub brokers, employees or agents assisting the Business Associate in the performance of its obligations under the Agreement and/or this Addendum, available to the Covered Entity at no cost to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy which involves inaction or actions by the Business Associate, except where Business Associate or its sub broker, employee or agent is a named as an adverse party.

F. Access to Protected Health Information. Business Associate shall make the PHI maintained by Business Associate or its agents or sub brokers available in Designated Record Sets to Covered Entity for inspection and copying within ten (10) days of a request by Covered Entity to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524[lvii] and consistent with Section 13405 of the HITECH Act. Business Associate agrees to provide access to Protected Health Information, at the request of Covered Entity, in the time and manner designated, in a Designated Record Set,

to Covered Entity or, as directed by Covered Entity, to an Individual, in order to meet the requirements under 45 CFR 164.524[lvii]. Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of the Covered Entity, available to the Secretary of the United States Dept. of Health and Human Services, in a time and manner specified by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining the Covered Entity's compliance with the Privacy Rule.

G. Amendment of PHI. Within ten (10) days of receipt of a request from Covered Entity for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Business Associate or its agents or sub brokers shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526[lviii]. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526[lviii] at the request of Covered Entity or an Individual, and in the time and manner specified by the Covered Entity.

H. Access to Records. Business Associate shall make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use, access and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, and/or to the Secretary for the U.S. Department of Health and Human Services, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules and patient confidentiality regulations, consistent with 45 CFR 164.504. The respective rights and obligations of Business Associate under this section of this Addendum shall survive the termination of the Agreement.

I. Individual's Right to Access, Amend and Accounting of Disclosure(s). The Business Associate shall make available to the specific Individual to whom it applies any PHI; make such PHI available for amendment; and make available the PHI required to provide an accounting of disclosures, all to the extent required by 45 CFR §§ 164.524[lvii], 164.526[lviii], and 164.528[lix] respectively. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528[lix]. Business Associate agrees to provide to the Covered Entity or an Individual, in a time and manner specified by the Covered Entity, information collected in accordance with the Agreement, to permit the

Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528[lix] and the HITECH Act.

J. Security. The Business Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, the compliance with 74 FR 19006, "Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII" is required. If Business Associate chooses not to adopt such methodologies as defined in 74 FR 19006 based on its Security Risk Analysis, Business Associate shall document such rationale and submit it to the Covered Entity.

K. Duties at Termination. Upon termination of the Agreement and/or this Addendum for any reason, Business Associate shall return all Protected Health Information, in whatever form, required to be retained and return or destroy all other Protected Health Information received from the Covered Entity, or created or received by the Business Associate or its sub brokers, employees or agents on behalf of the Covered Entity. In the event the Business Associate determines that returning the Protected Health Information is not feasible, the Business Associate shall provide the Covered Entity with written notification of the conditions that make return not feasible. The Covered Entity shall be the final authority in determining whether the return of PHI is not feasible. However, the Covered Entity shall not unreasonably withhold its consent from Business Associate as to the feasibility of the return of PHI. Business Associate further agrees to extend any and all protections, limitations, and restrictions contained in the Agreement and/or this Addendum, to any Protected Health Information retained by Business Associate or its sub brokers, employees or agents after the termination of the Agreement and/or this Addendum. These protections, limitations and restriction shall also apply to all agents and sub brokers of Business Associate. The Business Associate shall limit any further use, access or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible. This shall also apply to all agents and sub brokers of Business Associate. The duty of the Business Associate and its agents and sub brokers to assist the Covered Entity with any HIPAA required accounting of disclosures survives the termination of the Agreement and this Addendum.

L. Termination for Cause. Covered Entity may terminate the Agreement if at any time it determines that the Business Associate has violated a material term of the Agreement or this Addendum. Covered Entity may, at its sole discretion, allow Business Associate a reasonable period of time to cure the violation before termination.

M. Breach Pattern or Practice by Covered Entity. Pursuant to 42 U.S.C. Section l7934(b), if the Business Associate knows of a pattern of activity or practice of the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under this

Addendum, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the Addendum if feasible, or if termination is not feasible, report the problem to the Secretary of United States Department of Health and Human Services.

N. Judicial or Administrative Proceedings. The Covered Entity may terminate this Addendum if Business Associate is found guilty of a criminal violation of HIPAA. The Covered Entity may terminate this Addendum if a finding or stipulation is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined that the Business Associate has violated any standard or requirement of HIPAA, HITECH or other security or privacy Jaws. Business Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA and/or HITECH and shall be responsible for any and all costs associated with prosecution.

O. Sub brokers and Agents. The Business Associate will require any of its sub brokers and agents, to which the Business Associate is permitted by this Addendum or in writing by the Covered Entity to disclose the Covered Entity's Protected Health Information and/or Electronic Protected Health Information, to provide reasonable assurance that such sub broker or agent will comply with the same privacy and security safeguard obligations with respect to the Covered Entity's Protected Health Information and/or Electronic Protected Health Information that are applicable to the Business Associate under this Addendum.

P. Designation of Compliance Official and Contact Individual. The Business Associate shall designate a compliance official who shall be responsible for the development and implementation of policies and procedures required of Business Associate under this Addendum. A compliance official shall be designated for each subsidiary that is a Business Associate. The Business Associate shall designate a contact individual or office for receiving complaints and shall provide documentation of such designation to the Covered Entity. The contact individual or office must be able to provide information about matters that are covered in the privacy notice.

3. Specific Use and Disclosure Provisions.

A. Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

B. Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosure is required by law.

C. Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation service to Covered Entity as permitted by 42 CFR 164.504 (e) (2) (i) (B).

D. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 42 CFR l64.502 (G)(l).

4. Obligations of Covered Entity.

A. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520[lx], to the extent that such limitation may affect Business Associate's use, access or disclosure of Protected Health Information.

B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an individual to use, access or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use, access or disclosure of Protected Health Information.

C. Covered Entity shall notify Business Associate of any restriction to the use, access or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522[lxi], to the extent that such restriction may affect Business Associate's use, access or disclosure of Protected Health Information.

D. Covered Entity shall complete the following in the event that the Covered Entity has determined that Business Associate has a breach:

i. Detem1ine appropriate method of notification to the Client/Patient(s) regarding a breach as outlined under Section 13402(e) of the HITECH Act.

ii. Send notification to the Client/Patient(s) without unreasonable delay but in no case later than sixty (60) days of discovery of the breach with at least the minimal required elements as follows:

a. A brief description of what happened, including the date of the Breach and

the date of discovery;

b. A description of the types of unsecured PHI involved in the Breach (such as name, date of birth, home address, Social Security number, medical insurance, etc.);

c. The steps Client/Patient(s) should take to protect themselves from potential harm resulting from the breach.

iii. Determine if notice is required to Secretary of the United States Department of Health and Human Services.

iv. Submit breach information to the Secretary of the U.S. Department of Health and Human Services within the required timeframe, in accordance with 45 CFR 164.408(b).

5. General Provisions.

A. Remedies. Business Associate agrees that Covered Entity shall be entitled to seek immediate injunctive relief as well as to exercise all other rights and remedies which Covered Entity may have at law or in equity in the event of an unauthorized use, access or disclosure of Protected Health Information by Business Associate or any agent or sub broker of Business Associate that received Protected Health Information from Business Associate.

B. Ownership. The Protected Health Information shall be and remain the property of the Covered Entity. Business Associate agrees that it acquires no title or rights to the Protected Health Information.

C. Regulatory References. A reference in this Addendum to a section in the HIPAA Privacy and Security Rules and patient confidentiality regulations means the section as in effect or as amended.

D. Amendment. The Parties agree to take such action as is necessity to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Privacy and Security Rules and the Health Insurance Portability and Accountability Act and patient confidentiality regulations.

E. Interpretation. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules and patient confidentiality regulations.

F. Secondary PHI. Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an Individual must be held confidential and is also the property of Covered Entity.

G. Electronic Transmission. Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an Individual must not be transmitted to another party by electronic or other means for additional uses not authorized by this Addendum or to another broker, or allied agency, or affiliate without prior written approval of Covered Entity.

H. No Sales. Reports or data containing the PHI may not be sold without Covered Entity's or the affected Individual's written consent.

I. No Third-Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

J. This Addendum constitutes the entire Business Associate Agreement Addendum and supersedes all prior Business Associate Agreement Addendum and understandings, both written and oral, among the Parties with respect to the subject matter of this Addendum.

K. This Addendum shall be binding upon, inure to the benefit of, and be enforceable by and against the Parties and their respective heirs, personal representatives, successors, and assigns. Neither this Agreement nor any of the rights, interests or obligations under this Addendum shall be transferred or assigned by the Business Associate without the prior written consent of the Covered Entity.

L. With respect to any provision of this Addendum finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Addendum cannot be reformed, such provision shall be deemed severed from this Agreement, but every other provision of this Addendum shall remain in full

force and effect. This Addendum shall be governed by, and construed in accordance with, the laws of the State of Rhode Island.

M. All representations, covenants, and agreements in or under the Agreement and/or this Addendum, or any other documents executed in connection with the transactions contemplated by the Agreement and/or this Addendum, shall survive the execution, delivery, and performance of this Addendum and such other documents.

N. Each Party shall execute, acknowledge or verify, and deliver any and all documents that may, from time to time, be reasonably requested by the other Party to carry out the purpose and intent of this Addendum.

6. Acknowledgment.

A. Notwithstanding any other requirement set out in this Addendum, the Broker acknowledges and agrees that the HITECH Act and its implementing regulations impose new requirements with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health and Human Services. The HITECH requirements, regulations and provisions are hereby incorporated by reference into this Addendum as if set forth in this Addendum in their entirety. Notwithstanding anything to the contrary or any provision that may be more restrictive within this Addendum, all requirements and provisions of HITECH, and its implementing regulations currently in effect and promulgated and/or implemented after the date of this Addendum, are automatically effective and incorporated herein. Where this Addendum requires stricter guidelines, the stricter guidelines must be adhered to.

B. By signing this Addendum, the Business Associate agrees that this Addendum shall binding during the Interim Final Rules and until such time as Final Rules are promulgated and a new Business Associate Agreement Addendum is signed based on the Final Rules. The Business Associate agrees that it shall sign a new Addendum based on the new Final Rules when presented by the Department of Human Services.

C. The undersigned affirms that he/she is a duly authorized representative of the Business Associate for which he/she is signing and has the authority to execute this Addendum on behalf of the Business Associate.

ADDENDUM XIII

REQUEST FOR PROPOSAL SCOPE OF WORK

Please refer to RFP document for bid proposal and scope of work.

ADDENDUM XIV

BUDGET

Medicaid benefit payments are processed through the MMIS system. ATTACHMENT A identifies the capitation rates paid by EOHHS to the Broker.

ADDENDUM XV

FEDERAL SUBAWARD REPORTING

PAYMENTS

IMPORTANT ITEMS TO NOTE ABOUT NEW REQUIREMENT

-- The Federal Funding Accountability and Transparency Act (FFATA or Transparency Act - P.L.109-282, as amended by section 6202(a) of P.L. 110-252) requires the Office of Management and Budget (OMB) to maintain a single, searchable website that contains current information on all Federal spending awards. That site is at www.USASpending.gov.

--Includes both mandatory and discretionary grants

--Do not include grants funded by the Recovery Act (ARRA)

--For more information about Federal Spending Transparency, refer to http://www.whitehouse.gov/omb/open

--If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award will be subject to the reporting requirements, as of the date the award exceeds $25,000

--If the initial award equals or exceeds $25,000 but funding is subsequently de-obligated such that the total award amount falls below $25,000, the award continues to be subject to the reporting requirements of the Transparency ACT and this Guidance.

ADDENDUM XVI

LIQUIDATED DAMAGES

THE PROSPECTIVE PRIMARY PARTICIPANT BROKER AGREES THAT TIME IS OF THE ESSENCE IN THE PERFORMANCE OF CERTAIN DESIGNATED PORTIONS OF THIS CONTRACT. THE EXECUTIVE OFFICE AND THE BROKER AGREE THAT IN THE EVENT OF A FAILURE TO MEET THE MILESTONES AND PROJECT DELIVERABLE DATES OR ANY STANDARD OF PERFORMANCE WITHIN THE TIME SET FORTH IN THE EXECUTIVE OFFICE'S BID PROPOSAL AND THE BROKER'S PROPOSAL RESPONSE (ADDENDUM XVI), DAMAGE SHALL BE SUSTAINED BY THE EXECUTIVE OFFICE AND THAT IT MAY BE IMPRACTICAL AND EXTREMELY DIFFICULT TO ASCERTAIN AND DETERMINE THE ACTUAL DAMAGES WHICH THE EXECUTIVE OFFICE WILL SUSTAIN BY REASON OF SUCH FAILURE. IT IS THEREFORE AGREED THAT EXECUTIVE OFFICE, AT ITS SOLE OPTION, MAY REQUIRE THE BROKER TO PAY LIQUIDATED DAMAGES FOR SUCH FAILURES WITH THE FOLLOWING PROVISIONS:

1. WHERE THE FAILURE IS THE SOLE AND EXCLUSIVE FAULT OF THE EXECUTIVE OFFICE, NO LIQUIDATED DAMAGES SHALL BE IMPOSED. TO THE EXTENT THAT EACH PARTY IS RESPONSIBLE FOR THE FAILURE, LIQUIDATED DAMAGES SHALL BE REDUCED BY THE APPORTIONED SHARE OF SUCH RESPONSIBILITY.

2. FOR ANY FAILURE BY THE BROKER TO MEET ANY PERFORMANCE STANDARD, MILESTONE OR PROJECT DELIVERABLE, THE EXECUTIVE OFFICE MAY REQUIRE THE BROKER TO PAY LIQUIDATED DAMAGES IN THE AMOUNT(S) AND AS SET FORTH IN THE STATE'S GENERAL CONDITIONS OF PURCHASE AS DESCRIBED PARTICULARLY IN THE LOI, RFP, RFQ, OR SCOPE OF WORK, HOWEVER, ANY LIQUIDATED DAMAGES ASSESSED BY THE EXECUTIVE OFFICE SHALL NOT EXCEED_ 10 _% OF THE TOTAL AMOUNT OF ANY SUCH MONTH’S INVOICE IN WHICH THE LIQUIDATED DAMAGES ARE ASSESSED AND SHALL NOT IN THE AGGREGATE, OVER THE LIFE OF THE AGREEMENT, EXCEED THE TOTAL CONTRACT VALUE.

WRITTEN NOTIFICATION OF FAILURE TO MEET A PERFORMANCE REQUIREMENT SHALL BE GIVEN BY THE EXECUTIVE OFFICE'S PROJECT OFFICER TO THE BROKER’S PROJECT OFFICER. THE BROKER SHALL HAVE A REASONABLE PERIOD DESIGNATED BY THE EXECUTIVE OFFICE FROM THE DATE OF RECEIPT OF WRITTEN NOTIFICATION. IF THE FAILURE IS NOT MATERIALLY

RESOLVED WITHIN THIS PERIOD, LIQUIDATED DAMAGES MAY BE IMPOSED RETROACTIVELY TO THE DATE OF EXPECTED DELIVERY.

IN THE EVENT THAT LIQUIDATED DAMAGES HAVE BEEN IMPOSED AND RETAINED BY THE EXECUTIVE OFFICE, ANY SUCH DAMAGES SHALL BE REFUNDED, PROVIDED THAT THE ENTIRE SYSTEM TAKEOVER HAS BEEN ACCOMPLISHED AND APPROVED BY THE EXECUTIVE OFFICE ACCORDING TO THE ORIGINAL SCHEDULE DETAILED IN THE BROKER'S PROPOSAL RESPONSE INCLUDED IN THIS CONTRACT (ADDENDUM XVI) AS MODIFIED BY MUTUALLY AGREED UPON CHANGE ORDERS.

TO THE EXTENT LIQUIDATED DAMAGES HAVE BEEN ASSESSED, SUCH DAMAGES SHALL BE THE SOLE MONETARY REMEDY AVAILABLE TO THE EXECUTIVE OFFICE FOR SUCH FAILURE. THIS DOES NOT PRECLUDE THE STATE FROM TAKING OTHER LEGAL ACTION.

ADDENDUM XVII

EQUAL EMPLOYMENT OPPORTUNITY

DURING THE PERFORMANCE OF THIS AGREEMENT, THE BROKER AGREES AS FOLLOWS:

1. THE BROKER SHALL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT FOR EMPLOYMENT RELATING TO THIS AGREEMENT BECAUSE OF RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY, UNLESS RELATED TO A BONA FIDE OCCUPATIONAL QUALIFICATION. THE BROKER SHALL TAKE AFFIRMATIVE ACTION TO ENSURE THAT APPLICANTS ARE EMPLOYED AND EMPLOYEES ARE TREATED EQUALLY DURING EMPLOYMENT, WITHOUT REGARD TO THEIR RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, OR PHYSICAL OR MENTAL DISABILITY.

   SUCH ACTION SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING: EMPLOYMENT, UPGRADING, DEMOTIONS, OR TRANSFERS; RECRUITMENT OR RECRUITMENT ADVERTISING; LAYOFFS OR TERMINATIONS; RATES OF PAY OR OTHER FORMS OF COMPENSATION; AND SELECTION FOR TRAINING INCLUDING APPRENTICESHIP. THE BROKER AGREES TO POST IN CONSPICUOUS PLACES AVAILABLE TO EMPLOYEES AND APPLICANTS FOR EMPLOYMENT NOTICES SETTING FORTH THE PROVISIONS OF THIS NONDISCRIMINATION CLAUSE.

2. THE BROKER SHALL, IN ALL SOLICITATIONS OR ADVERTISING FOR EMPLOYEES PLACED BY OR ON BEHALF OF THE BROKER RELATING TO THIS AGREEMENT, STATE THAT ALL QUALIFIED APPLICANTS SHALL RECEIVE CONSIDERATION FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, SEX, NATIONAL ORIGIN, ANCESTRY, AGE, PHYSICAL OR MENTAL DISABILITY.

3. THE BROKER SHALL INFORM THE CONTRACTING EXECUTIVE OFFICE'S EQUAL EMPLOYMENT OPPORTUNITY COORDINATOR OF ANY DISCRIMINATION COMPLAINTS BROUGHT TO AN EXTERNAL REGULATORY BODY (RI ETHICS COMMISSION, RI DEPARTMENT OF ADMINISTRATION, US DHHS OFFICE OF CIVIL RIGHTS) AGAINST THEIR

AGENCY BY ANY INDIVIDUAL AS WELL AS ANY LAWSUIT REGARDING ALLEGED DISCRIMINATORY PRACTICE.

4. THE BROKER SHALL COMPLY WITH ALL ASPECTS OF THE AMERICANS WITH DISABILITIES ACT (ADA) IN EMPLOYMENT AND IN THE PROVISION OF SERVICE TO INCLUDE ACCESSIBILITY AND REASONABLE ACCOMMODATIONS FOR EMPLOYEES AND CLIENTS.

5. BROKERS AND SUB BROKERS WITH AGREEMENTS IN EXCESS OF $50,000 SHALL ALSO PURSUE IN GOOD FAITH AFFIRMATIVE ACTION PROGRAMS.

6. THE BROKER SHALL CAUSE THE FOREGOING PROVISIONS TO BE INSERTED IN ANY SUBCONTRACT FOR ANY WORK COVERED BY THIS AGREEMENT SO THAT SUCH PROVISIONS SHALL BE BINDING UPON EACH SUB BROKER, PROVIDED THAT THE FOREGOING PROVISIONS SHALL NOT APPLY TO CONTRACTS OR SUBCONTRACTS FOR STANDARD COMMERCIAL SUPPLIES OR RAW MATERIALS.

ADDENDUM XVIII

BID PROPOSAL

Bid Proposal is Incorporated Here.

ADDENDUM XIX

CORE STAFF & BROKER LOCATION

To Be Completed by Broker.

ATTACHMENT A

BROKER'S CAPITATION RATES SFY 2019

Please refer to RFP document.

ATTACHMENT B

BROKER'S INSURANCE CERTIFICATES

Broker to Complete.

ATTACHMENT C

RATE-SETTING PROCESS

Please refer to RFP document. To Be Determined between the Broker and The Executive Office of Health and Human Services.

ATTACHMENT D

PERFORMANCE GOALS

To Be Determined between

the Broker and The

Executive Office of Health

and Human Services.

ATTACHMENT E

REPORTING CALENDAR

To Be Determined between

the Broker and The

Executive Office of Health

and Human Services.

ATTACHMENT F

BORDER COMMUNITIES

Please refer to Executive Office of Health and Human Service's policy, and base contract.

ATTACHMENT G

COVERED SERVICES FOR TRANSPORTATION

Please refer to base of contract.

Hewlett Packard Enterprise

Executive Office of Health and Human Services

Standard Companion Guide Transaction Information

Rhode Island Medicaid

Instructions related to 837 Transactions based on ASC X12 Implementation Guides, version 005010
Encounter Data

Version 2.6

Hewlett Packard Enterprise

Revision History

VERSION	DATE	SECTION REVISED	REASON FOR REVISION
2.0	2.10.15	Cover Page	New EOHHS logo
2.1	2.9.15	Loop 2300 HI Segment	Clarification of language for mixing of ICD9 and ICD10 codes
2.2	3.17.15	Various Sections- MID fields	UHIP
2.3	3.26.15	837 Prof loop 2310E&F	837 Professional Loop 2310E&F added
2.4	11.1.15	Logo, name change	HP Separation
2.5	7.7.16	Loop 2330A, 2010BA, 2300; *Note* update to TP listed, pg.s 6, 23 & 50; Instructional update to additional guidance in multiple sections; *Note* update to ICD-10 code reference in multiple sections; MID instructions for claims processing requirements in multiple sections	ICI 834 MMEDS Addendums, Professional, Instituional, & Dental. March 2016.
2.6	1.17.17	Modified Type of Bill as follows: Added Type of Bill 9 for Other. Added Inpatient TOB 3, 8, 9 to First Digit Column. Added Inpatient TOB 3, 4 to Second Digit Column. Added Outpatient TOB 7 to First Digit Column. Added Outpatient TOB 2, 5, 9 to Second Digit Column. Removed frequency type of bill 0, 5 and 6. These modifications were made to assist the health plans with claims being rejected at the translator level.	Updated for TOB added to translator maps
	1.18.2017	Removed outdated business rule for ABK qualifier. This applied to pre- ICD10 implementation. Also added verbiage on top of page 47 to provide clarification between Encounter and FFS Types of Bill.	Removed no longer valid

Table of Contents

1. Introduction 4
1.1. Purpose 4
2. 005010X224A2 Health Care Claim: Dental 5
3. 005010X222A1 Health Care Claim: Professional 24
3.1 Table of Valid Type of Bill Code 47
4. 005010X223A2 Health Care Claim: Institutional 49
5. Appendix A 72
6. Appendix B 75

1. Introduction

This guide is provided to assist RI Medicaid Providers and their Agents with the process of registering to exchange Electronic Data Interchange (EDI) transactions with RI Medicaid, to prepare for Level 6 (Specialty Line of Business) testing with RI Medicaid, and to utilize the RI Medicaid Portal, a web enabled interface, to send and receive X12N transactions for the purpose of submitting for RI Title XIX Services. Denied claims are excluded from these transactions and should not be submitted.

1.1. Purpose

These specifications are to be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3. These reports can be obtained from the Washington Publishing Company at www.wpc-edi.com. The RI Medicaid 837 Encounter Claim Utilization Companion Guide provides supplemental information specific to RI Medicaid as permitted within the HIPAA transaction sets. Specifications may be updated as necessary.

Detailed information on Program Rules, Covered Services, and Billing Guidelines are part of the Title XIX Provider Reference Guides and Provider Update Newsletter. Both are available on the Executive Offices of Health and Human Services (EOHHS) website.

HIPAA does not mandate that only X12N transactions can be used to exchange healthcare data. That being said, it is the expectation of the RI Medicaid program that claim utilization reporting from participating Managed Care Health Plans will be in the X12N 837 standard for Professional, Institutional and Dental claims.

2. 005010X224A2 Health Care Claim: Dental

PRE-HEADER		
Segment	**ISA Interchange Information**	
Reference	**Name**	**Rhode Island Requirements**
ISA01	Authorization Information Qualifier	Populate with '00'
ISA03	Security Information Qualifier	Populate with '00'
ISA05	Interchange ID qualifier	Populate with qualifier 'ZZ'
ISA06	Interchange sender ID	Populate with Trading Partner ID assigned by RI Medicaid
ISA07	Interchange ID qualifier	Populate with 'ZZ'
ISA08	Interchange Receiver ID	Use the RI EIN '056000522'
Segment	**GS Functional Group Header**	
Reference	**Name**	**Rhode Island Requirements**
GS02	Application Sender Code	Populate with Trading Partner ID assigned by RI Medicaid
GS03	Application Receiver Code	Populate with RI Medicaid EIN '056000522'
GS08	Version Identifier Code	Populate with '005010X224A2'

HEADER		
Segment	**ST Transaction Set Header**	
Reference	**Name**	**Rhode Island Requirements**
ST03	Implementation Convention Reference	Populate with '005010X224A2' **Page 2 Dental Guide Section 1.3.2** "The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to higher limits. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA".
Segment	**BHT Beginning of Hierarchical Transaction**	
Reference	**Name**	**Rhode Island Requirements**
BHT06	Transaction Type Code	Populate with 'RP'-Reporting for Encounter transactions

Note: Health Plans will continue to use their existing Trading Partner IDs to submit the new encounter claim utilization files. A unique Trading Partner already exists for each plan/program (i.e Rite Care, Rhody Health Partners, NHPRI ICI Phase 2, etc).

LOOP ID	**1000A SUBMITTER NAME**	
Segment	**NM1 Submitter Name**	
Reference	**Name**	**Rhode Island Requirements**
NM109	Submitter Identifier	Populate with Health Plan Trading Partner ID assigned by RI Medicaid
Segment	**PER Submitter EDI Contact Information**	
Reference	**Name**	**Rhode Island Requirements**
PER01	Submitter Identifier	RI Medicaid will only capture the information in the first PER segment (this would be the Health plan's contact information).

LOOP ID	**1000B RECEIVER NAME**	
Segment	**NM1 Receiver Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Receiver Name	Populate with 'RI Medicaid'
NM109	Identification code	Populate with RI Medicaid EIN '056000522'

LOOP ID	**2000A BILLING PROVIDER**	
Segment	**PRV Billing Provider Specialty Information**	
Reference	**Name**	**Rhode Island Requirements**
PRV01	Billing Provider Specialty Information	Populate with 'BI' (Billing Provider)
PRV02	Reference Identification Qualifier	Populate with 'PXC' (Taxonomy Qualifier)
PRV03	Provider Taxonomy Code	Populate with Billing Provider taxonomy Required when reporting the Billing Provider NPI in Loop 2010AA

LOOP ID	**2010AA Billing Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	(Billing Provider's Last Name or Organization Name) This value corresponds to the billing provider name as reported on the original claim
NM108	Identification Code Qualifier	Populate with 'XX' (To be blank if reporting atypical billing provider)

LOOP ID	2010AA Billing Provider Tax Identification	
Segment	REF Billing Provider Secondary Identification	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with billing provider's Tax ID information: EI = Employers Identification Number; SY = Social Security Number
REF02	Reference Identification	Billing Provider's tax identification number OR the Provider's SSN

LOOP ID	2000B SUBSCRIBER HIERARCHICAL	
Segment	HL Subscriber Hierarchical Level	
Reference	Name	Rhode Island Requirements
HL04	Hierarchical Child Code	Populate with '0' The subscriber is the patient for all RI claims as per RI Medicaid claims submission standards.
Segment	SBR Subscriber Information	
Reference	Name	Rhode Island Requirements
SBR01	Payer Responsibility Sequence Number Code	Health Plans should send in any of the valid values of 'P'-Primary 'S'-Secondary or 'T'-Tertiary as to how the Health Plan is paying for the recipients payment.
SBR09	Claim Filing Indicator	Populate with 'MC'

LOOP ID	2010BA SUBSCRIBER NAME	
Segment	NM1 Subscriber Name	
Reference	Name	Rhode Island Requirements
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with qualifier 'MI' (Member Identification Number)
NM109	Identification Code	Populate with 10 digit RI Medicaid Recipient Identification Number (MID) Encounter claims processing requires 10-digits for successful processing.

LOOP ID	2010 BB PAYER NAME	
Segment	NM1 Payer Name	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Name of the Health Plan
NM108	Identification Code Qualifier	Populate with 'PI'- Payor Identification
NM109	Identification Code	Populate with **Health Plan's Tax ID**

LOOP ID	2010 BB PAYER NAME	
Segment	REF Billing Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers ONLY in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan Do not populate this field for providers that have an NPI
REF02	Payer Additional Identifier	Populate this field with the MMIS provider legacy ID (7 characters) that will be returned in the initial provider network exchange. The provider must come from an approved provider list for Atypical providers. This field is ONLY to be used in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI

Header Section of claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	**CLM Claim Information**	
Reference	**Name**	**Rhode Island Requirements**
CLM01	Patient Account Information	RI will capture first 20 characters for encounter purposes.
CLM02	Total Claim Charge Amt	Rhode Island is expecting the total claim charge amount in this field.
CLM05-3	Claim Frequency Type Code	Populate with '1', '7' or '8' 1=Original Claim 7= Adjustment 8=Void *Any other value submitted in this field will result in the entire ST-SE segment being rejected.* *Please see Adjustment document for adjustment examples.*

LOOP ID	2300 CLAIM INFORMATION	
Segment	**DTP Date-Accident**	
Reference	**Name**	**Rhode Island Requirements**
DTP03	Date Time Period	If reporting an accident, Rhode Island is expecting the Accident date on the claim in CCYYMMDD format if it was used on the claim.
Segment	**DTP-Appliance Placement**	
DTP03	Date Time Period	This information is required if present on the original claim. RIMA is expecting Date of Appliance Placement in CCYYMMDD format.
Segment	**DTP-Date Service**	
DTP03	Date Time Period	This is required. Rhode Island expects the From and To Dates of Service on the claim in CCYYMMDD or CCYYMMDD CCYYMMDD format
Segment	**DTP-Prior Placement**	
DTP03	Date Time Period	Rhode Island is expecting Prior Placement Date, in CCYYMMDD format if present on the original claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	DN1 Orthodontic Total Months of Treatment	
Reference	**Name**	**Rhode Island Requirements**
DN101	Quantity	This is required for the reporting of Orthodontic treatment services. The value to be reported in this field corresponds to the number of months for Orthodontic treatment.
DN102	Quantity	This is required for the reporting of Orthodontic treatment services. The value to be reported in this field corresponds to the remaining number of months for Orthodontic treatment.

LOOP ID	2300 CLAIM INFORMATION	
Segment	CN1 Contract Information	
Reference	**Name**	**Rhode Island Requirements**
CN101	Contract Type Code	This is required if the service rendered was part of an existing sub-capitated arrangement between the health plan and the billing provider. Populate with '05' (Capitated) for services rendered as part of a sub-capitated arrangement.

LOOP ID	2300 CLAIM INFORMATION	
Segment	AMT Patient Amount Paid	
Reference	**Name**	**Rhode Island Requirements**
AMT02	Monetary Amount	If the recipient has paid for any portion of the service being reported on the claim, that dollar amount should be reported here.

LOOP ID	2300 CLAIM INFORMATION	
Segment	NM1 Subscriber Name	
Reference	**Name**	**Rhode Island Requirements**
REF02	Payer Claim Control Number	This information is required. The Payer claim control number is the health plan's original ICN. This should be sent on all claims. To initiate adjustments or voids, the payer claim control number should be sent with a claim frequency type code (CLM05-3) of '7'-(Adjustment) or '8'-(Void). ***Note—When submitting a claim adjustment, Health Plan should always use the original claim identifier assigned by the adjudicating health plan assigned to the original paid claim as reported and applied to the MMIS. ***

LOOP ID	2300 CLAIM INFORMATION	
Segment	REF Prior Authorization	
Reference	**Name**	**Rhode Island Requirements**
REF02	Prior Authorization or Referral Number	This is required if a **Prior Authorization Number** is present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	HI Health Care Diagnosis Code	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Code List Qualifier Code	Populate with 'BK' for submission of ICD-9 codes or 'ABK' for submission of ICD-10 codes. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI01-2	Principal Diagnosis Code	Populate with applicable ICD-9 or ICD-10 code. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI02 -1	Code List Qualifier Code	Populate with 'BF' for submission of ICD-9 codes or 'ABF' for submission of ICD-10 codes. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI02 -2	Diagnosis Code	Populate with applicable ICD-9 or ICD-10 code. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HCP Claim Pricing/Repricing Information**	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. *Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.*
HCP02	Monetary Amount	Populate with allowed amount from health plan

LOOP ID	2310A REFERRING PROVIDER NAME	
Segment	**NM1 Referring Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Referring Provider Last Name
NM108	Identification Code Qualifier	Populate with 'XX' or blank

LOOP ID	2310A REFERRING PROVIDER NAME	
Segment	**PRV Referring Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
PRV01	Referring Provider Specialty Information	Populate with 'RF'
PRV02	Reference Identification Qualifier	Populate with 'PXC'
PRV03	Referring Provider Taxonomy Code	Populate with Referring Provider taxonomy Required when reporting a Referring Providers NPI

LOOP ID	2310A REFERRING PROVIDER NAME	
Segment	REF Referring Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers ONLY in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI.
REF02	Reference Identification	This field is ONLY to be used in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI.

LOOP ID	2310B RENDERING PROVIDER NAME	
Segment	NM1 Rendering Provider Name	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Rendering Provider Last Name
NM108	Identification Code Qualifier	Populate with 'XX'
LOOP ID	2310B RENDERING PROVIDER NAME	
Segment	PRV Rendering Provider Specialty Information	
Reference	**Name**	**Rhode Island Requirements**
PRV01	Rendering Provider Specialty Information	Populate with 'PE'
PRV02	Reference Identification Qualifier	Populate with 'PXC'
PRV03	Rendering Provider Taxonomy Code	Populate with Rendering Provider taxonomy Required when reporting a Rendering Providers NPI

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	**NM1 Service Facility Location Name**	
Reference	Name	Rhode Island Requirements
NM103	Name Last or Organization Name	Populate with Name Last or Organization Name In the NM103 you can use the Last name or the Organization name. Example of 837D NM1*77*2*ABC CLINIC~ *Note: Please do not send the NM108 or NM109~*

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	**N3 Service Facility Location Address**	
Reference	Name	Rhode Island Requirements
N301	Address Information	Address information can be up to 55 bytes Example of 837D: N3*JOE JAY LANE~

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	**N4 Service Facility Location City, State, Zip Code**	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	Populate with City State and Zip Report valid City, State and Zip information. Example of 837D: N4*FORESTDALE*MA*026441109~

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	REF Service Facility Location Secondary Identification	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with 'LU' Location Number
REF02	Reference Identification	This information is **Optional** for all claims. Populate with unique Location Number assigned by the health plan that links a provider to a specific location (which will be reported by the health plan in the MCO Provider Network file submission). This location code will link the rendering provider to the address where the actual service was performed. Example of 837D: REF*LU*1234567~

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	SBR Other Subscriber Information	
Reference	Name	Rhode Island Requirements
SBR01	Payer Responsibility Sequence Number Code	Health Plan should send in 'U'-Unknown for all iterations of this loop
SBR09	Claim Filing Indicator	**This information is required for all claims.** **Populate with 'MC' (Medicaid)** RI Medicaid also requires additional segments of the 2320 if any TPL information was factored into the Health Plan payment.
LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	CAS Claim Level Adjustments	
CAS01	Claim Adjustment Group Code	At least one CAS segment is required for every claim. **The first occurrence will correspond to the Health Plan claim payment information, and any subsequent occurrences must correspond to any other insurance payments made on the claim.**

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	AMT Coordination of Benefits (COB) Payer Paid Amount	
Reference	Name	Rhode Island Requirements
AMT02	Payer Paid Amount	**This information is required for all claims.** **For the first occurrence, this element will always contain the Health Plan's paid amount on the claim. Zero "0" is an acceptable value for this element for fee for service paid claims.** **For claims covered under a capitated arrangement, the participating health plan MUST 'shadow price' the claim.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the amount paid by the other insurance carrier.** If the Other Insurance Paid Amounts (Loop 2320) are greater than the Claim Billed Amount, the claim will be rejected.

LOOP ID	2330A OTHER SUBSCRIBER NAME	
Segment	NM1 Other Subscriber Name	
Reference	Name	Rhode Island Requirements
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with 'MI'-Member Identification Number
NM109	Identification Code	The first occurrence should be the 10 digit RI Medicaid Recipient Identification Number (MID) and for all subsequent occurrences, it should be the Other Insured Identifier Code. The 10-digit MID usage assumes post UHIP implementation; for claims submitted prior to UHIP, Phase 2, a 9-byte MID will be continued to be used.

LOOP ID	2330B OTHER PAYER NAME	
Segment	NM1 Other Payer Name	
Reference	Name	Rhode Island Requirements
NM109	Other Payer Primary Identifier	**This information is required for all claims** **For the first occurrence, this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov.

LOOP ID	2330B OTHER PAYER NAME	
Segment	N3 Other Payer Address	
Reference	Name	Rhode Island Requirements
N301	Other Payer Address Information	**For the first occurrence, this element will always contain the Health Plan's address.** Address information can be up to 55 bytes

LOOP ID	2330B OTHER PAYER NAME	
Segment	N4 Other Payer City, State, Zip Code	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	**For the first occurrence, this element will always contain the Health Plan's City State and Zip.** If reporting other insurance City State and Zip report valid City, State and Zip information

LOOP ID	2330B OTHER PAYER NAME	
Segment	DTP Date-Claim Check or Remittance Date	
Reference	Name	Rhode Island Requirements
DTP03	Adjudication or Payment Date	**For the first occurrence, this element will always contain the Health Plan's payment date.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the payment date of the other insurance carrier.** Rhode Island is expecting the Adjudication or Payment Date in CCYYMMDD format. *Note: The Header Paid date is ONLY required when the Health Plan is reporting Header only paid claims. If Reporting detail Paid claims DO NOT report Header paid date (reporting both dates will cause a compliance issue).*

Detail of Claim

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	SV3 Dental Service	
Reference	Name	Rhode Island Requirements
SV301-2	Procedure Code	Procedure code must be 5 characters or less If this field contains more than 5 characters, the claim will be rejected.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**TOO Tooth Information**	
Reference	**Name**	**Rhode Island Requirements**
TOO01	Code List Qualifier Code	RI Medicaid will only accept one TOO segment per detail. Multiple TOO segment on a single service will be rejected. Use multiple service lines to report services for multiple teeth.
Segment	**DTP-Date Service Date**	
DTP03	Date Time Period	Rhode Island is expecting the Service Date on the claim in CCYYMMDD if present on the original claim.
Segment	**DTP-Date Prior Placement**	
DTP03	Date Time Period	Rhode Island is expecting Prior Placement Date, in CCYYMMDD format if present on the original claim.
Segment	**DTP-Date Appliance Placement**	
DTP03	Date Time Period	Rhode Island is expecting Date of Appliance Placement, in CCYYMMDD format if present on the original claim.
Segment	**DTP-Date Replacement**	
DTP03	Date Time Period	Rhode Island is expecting Date of Replacement in CCYYMMDD format if present on the original claim.
Segment	**DTP-Date Treatment Start**	
DTP03	Date Time Period	Rhode Island is expecting Treatment Start Date, expressed in CCYYMMDD format if present on the original claim.
Segment	**DTP-Date Treatment Completion**	
DTP03	Date Time Period	Rhode Island is expecting Treatment completion date, expressed in CCYYMMDD format if present on the original claim.

Note: Please do not send in the Service Date with Treatment Start and Treatment Completion Date. This will cause the file to set a compliance error. To avoid the compliance error use either the Service Date, or Treatment Start and Treatment Completion Date but not both.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**REF Prior Authorization**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Reference Identification	This is required if a **Prior Authorization Number** is present and was used on the original claim.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**HCP Claim Pricing/Repricing Information**	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. ***Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.***
HCP02	Monetary Amount	Populate with allowed amount from health plan

LOOP ID	2420 RENDERING PROVIDER NAME	
Segment	NM1 Rendering Provider Name	
Reference	Name	Rhode Island Requirements
NM103	Name Last Organization Name	Populate with Rendering Provider Last Name
NM108	Identification Code Qualifier	Populate with 'XX or blank'

LOOP ID	2420A RENDERING PROVIDER NAME	
Segment	PRV Rendering Provider Specialty Information	
Reference	Name	Rhode Island Requirements
PRV01	Provider Code	Populate with 'PE'
PRV02	Reference Identification Qualifier	Populate with 'PXC'
PRV03	Reference Identification	Populate with Rendering Provider taxonomy This is required when reporting a Rendering Provider NPI.

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	SVD Line Adjudication Information	
Reference	Name	Rhode Island Requirements
SVD01	Identification Code	This is situational and to be used when reporting claims that are paid at the detail. **For Health Plan claims paid at the detail level, the first occurrence of this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code. When reporting this information, the number should match NM109 in Loop ID-2330B identifying Health Plan as the Other Payer.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer. Any additional other insurance carrier codes reported in this segment must be equal to NM109 in Loop 2330B identifying the other insurance carrier.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov. *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 32 of the 837 guide.*
SVD02	Monetary Amount	This is situational and to be used when reporting claims that are paid at the detail. **If reporting payment information at the claim detail, the first occurrence should be the Amount that was paid by the Health Plan for the specific claim detail.** **Subsequent occurrences may contain other payer detail line adjustment information.**

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	**CAS Line Adjustment**	
CAS01	Claim Adjustment Group Code	**This is required for any detail paid claims. The first occurrence should correspond to information related to the health plan's adjudication of the claim. Subsequent occurrences may contain other payer detail line adjustment information.**
Segment	**DTP Line Check or Remittance Date**	
DTP03	OI Paid Date	This is situational and to be used when reporting claims that are paid at the detail. The Detail Paid date is required when the Health Plan is reporting Detail paid claims. If Reporting detail Paid claims DO NOT report Header paid date. (Reporting both dates will cause a compliance issue). **If reporting payment information at the claim detail, the first occurrence should be the date the detail on the claim was paid by the Health Plan.** Populate with Adjudication or Payment date in CCYYMMDD format. *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 32 of the 837 guide*.

3. 005010X222A1 Health Care Claim: Professional

PRE-HEADER		
Segment	**ISA Interchange Information**	
Reference	**Name**	**Rhode Island Requirements**
ISA01	Authorization Information Qualifier	Populate with '00'
ISA03	Security Information Qualifier	Populate with '00'
ISA05	Interchange ID qualifier	Populate with qualifier 'ZZ'
ISA06	Interchange sender ID	Populate with Trading Partner ID assigned by RI Medicaid
ISA07	Interchange ID qualifier	Populate with 'ZZ'
ISA08	Interchange Receiver ID	Use the RI EIN '056000522'
Segment	**GS Functional Group Header**	
Reference	**Name**	**Rhode Island Requirements**
GS02	Application Sender Code	Populate with Trading Partner ID assigned by RI Medicaid. *Note: Health Plans will continue to use their existing Trading Partner IDs to submit the new encounter claim utilization files. A unique Trading Partner already exists for each plan/program (i.e Rite Care, Rhody Health Partners, NHPRI ICI Phase 2, etc).*
GS03	Application Receiver Code	Populate with RI Medicaid EIN '056000522'
GS08	Version Identifier Code	Populate with '005010X222A1'

HEADER		
Segment	**ST Transaction Set Header**	
Reference	**Name**	**Rhode Island Requirements**
ST03	Implementation Convention Reference	Populate with '005010X222A1' **Page 2 Professional Guide Section 1.3.2 states the following about usage of the ST SE Transaction Set Header segment** "The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to higher limits. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA".
Segment	**BHT Beginning of Hierarchical Transaction**	
Reference	**Name**	**Rhode Island Requirements**
BHT06	Transaction Type Code	Populate with 'RP'-Reporting for Encounter transactions

LOOP ID	1000A SUBMITTER NAME	
Segment	**NM1 Submitter Name**	
Reference	**Name**	**Rhode Island Requirements**
NM109	Submitter Identifier	Populate with Health Plan Trading Partner ID assigned by RI Medicaid
Segment	**PER Submitter EDI Contact Information**	
Reference	**Name**	**Rhode Island Requirements**
PER01	Submitter Identifier	RI Medicaid will only capture the information in the first PER segment (this would be the Health plan's contact information).

LOOP ID	1000B RECEIVER NAME	
Segment	**NM1 Receiver Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Receiver Name	Populate with 'RI Medicaid'
NM109	Identification code	Populate with RI Medicaid EIN '056000522'

LOOP ID	2000A BILLING PROVIDER	
Segment	PRV Billing Provider Specialty Information	
Reference	Name	Rhode Island Requirements
PRV01	Billing Provider Specialty Information	Populate with 'BI' (Billing Provider)
PRV02	Reference Identification Qualifier	Populate with 'PXC' (Taxonomy Qualifier)
PRV03	Provider Taxonomy Code	Populate with Billing Provider taxonomy Required when reporting the Billing Provider NPI in Loop 2010AA.

LOOP ID	2010AA Billing Provider Name	
Reference	Name	Rhode Island Requirements
NM103	Name Last Organization Name	(Billing Provider's Last Name or Organization Name) This value corresponds to the billing provider name as reported on the original claim.
NM108	Identification Code Qualifier	Populate with 'XX' (To be blank if reporting atypical billing provider).

LOOP ID	2010AA Billing Provider Tax Identification	
Segment	REF Billing Provider Secondary Identification	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with billing provider's Tax ID information: EI = Employers Identification Number; SY = Social Security Number
REF02	Reference Identification	Billing Provider's tax identification number OR the Provider's SSN

LOOP ID	2000B SUBSCRIBER HIERARCHICAL	
Segment	**HL Subscriber Hierarchical Level**	
Reference	**Name**	**Rhode Island Requirements**
HL04	Hierarchical Child Code	Populate with '0' The subscriber is the patient for all RI claims as per RI Medicaid claims submission standards.
Segment	**SBR Subscriber Information**	
Reference	**Name**	**Rhode Island Requirements**
SBR01	Payer Responsibility Sequence Number Code	Health Plans should send in any of the valid values of 'P'-Primary 'S'-Secondary or 'T'-Tertiary as to how the Health Plan is paying for the recipients payment.
SBR09	Claim Filing Indicator	Populate with 'MC'

LOOP ID	2010BA SUBSCRIBER NAME	
Segment	**NM1 Subscriber Name**	
Reference	**Name**	**Rhode Island Requirements**
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with qualifier 'MI' (Member Identification Number)
NM109	Identification Code	Populate with the10 digit RI Medicaid Recipient Identification Number (MID) Encounter claims processing requires 10-digits for successful processing.

LOOP ID	2010 BB PAYER NAME	
Segment	**NM1 Payer Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Name of the Health Plan
NM108	Identification Code Qualifier	Populate with 'PI'- Payor Identification
NM109	Identification Code	Populate with **Health Plan's Tax ID**

LOOP ID	2010 BB PAYER NAME	
Segment	REF Billing Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers. ONLY in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI
REF02	Payer Additional Identifier	This is the MMIS provider legacy ID (7 characters) that will be returned in the initial provider network exchange. The provider must come from an approved provider list for Atypical providers. This field is ONLY to be used in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI.

Header Section of claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	**CLM Claim Information**	
Reference	**Name**	**Rhode Island Requirements**
CLM01	Patient Account Information	RI will capture first 20 characters for encounter purposes.
CLM02	Total Claim Charge Amt	Rhode Island is expecting the total claim charge amount in this field.
CLM05-3	Claim Frequency Type Code	Populate with '1', '7' or '8' 1=Original Claim 7= Adjustment 8=Void *Any other value submitted in this field will result in the entire ST-SE segment being rejected.* *Please see Adjustment document for adjustment examples.*

LOOP ID	2300 CLAIM INFORMATION	
Segment	**DTP Date-Initial Treatment**	
Reference	**Name**	**Rhode Island Requirements**
DTP03	Date Time Period	This field can be used to report the date of a first prenatal visit. This information is to be reported if present on the original claim. The Initial Treatment Date should be submitted in CCYYMMDD format.
Segment	**DTP Date-Accident**	
Reference	**Name**	**Rhode Island Requirements**
DTP03	Date Time Period	This information is required if reporting an accident. RIMA expects the Accident date to be in CCYYMMDD format.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**DTP-Last Menstrual Period**	
DTP03	Date Time Period	This field can be used to report the date of a Last Menstrual Period. This information is to be reported if present on the original claim. The Last Menstrual Period should be submitted in CCYYMMDD format
LOOP ID	**2300 CLAIM INFORMATION**	
Segment	**CN1 Contract Information**	
Reference	**Name**	**Rhode Island Requirements**
CN101	Contract Type Code	This is required if the service rendered was part of an existing sub-capitated arrangement between the health plan and the billing provider. Populate with '05' (Capitated) for services rendered as part of a sub-capitated arrangement.
LOOP ID	**2300 CLAIM INFORMATION**	
Segment	**AMT Patient Amount Paid**	
Reference	**Name**	**Rhode Island Requirements**
AMT02	Monetary Amount	If the recipient has paid for any portion of the service being reported on the claim, that dollar amount must be reported here.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**REF Referral Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Prior Authorization or Referral Number	Populate with **Referral Number** if present on the original claim.)
Segment	**REF Prior Authorization**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Prior Authorization or Referral Number	This is required if **Prior Authorization Number** is present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**REF Payer Claim Control Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Payer Claim Control Number	This information is required. The Payer claim control number is the health plan's original ICN. This should be sent on all claims. To initiate adjustments or voids, the payer claim control number should be sent with a claim frequency type code (CLM05-3) of '7'-(Adjustment) or '8'-(Void). ***Note—When submitting a claim adjustment, Health Plan should always use the original claim identifier assigned by the adjudicating health plan assigned to the original paid claim as reported and applied to the MMIS. ***
Segment	**REF Care Plan Oversight**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Care Plan Oversight Number	Populate with Care Plan Oversight Number if present on the claim *Note: This would be the number of a home health or hospice agency. Only required when physicians are billing Medicare.*

LOOP ID	2300 CLAIM INFORMATION	
Segment	**CR1 Ambulance Transport Information**	
Reference	**Name**	**Rhode Island Requirements**
CR101	Unit or Basis for Measurement Code	Populate with value 'LB' – Pound if present on the original claim
CR102	Patient weight	Populate with the weight of the Patient at time of transport if present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	CRC EPSDT Referral	
Reference	**Name**	**Rhode Island Requirements**
CRC03-CRC05	Condition Code	Populate with Condition Code reported on the original claim. 'AV'-Available 'NU'-Not Used, 'S2'-Under Treatment, 'ST'-New Services Requested if present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	HI Health Care Diagnosis Code	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Code List Qualifier Code	Populate with 'BK' for submission of ICD-9 codes or 'ABK' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI01-2	Principal Diagnosis Code	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI02 through HI12) -1	Code List Qualifier Code	Populate with 'BF' for submission of ICD-9 codes or 'ABF' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI02 through HI12) -2	Diagnosis Code	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI Condition Information**	
(HI01 through HI12) -2	Code List Qualifier	Populate with 'BG' for Condition information
(HI01 through HI12) -2	Condition Code	Populate with Condition Code, if code is present and used on the original claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HCP Claim Pricing/Repricing Information**	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. ***Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.***
HCP02	Monetary Amount	Populate with allowed amount from health plan

LOOP ID	2310A REFERRING PROVIDER NAME	
Segment	**NM1 Referring Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Referring Provider Last Name if a Referring Provider was reported on the original claim
NM108	Identification Code Qualifier	Populate with 'XX' or blank

LOOP ID	2310A REFERRING PROVIDER NAME	
Segment	REF Referring Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with ‘G2’ for Atypical providers ONLY in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan
REF02	Reference Identification	This field is ONLY to be used in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI.

LOOP ID	2310B RENDERING PROVIDER NAME	
Segment	NM1 Rendering Provider Name	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Rendering Provider Last Name
NM108	Identification Code Qualifier	Populate with ‘XX’

LOOP ID	2310B RENDERING PROVIDER NAME	
Segment	**PRV Rendering Provider Specialty Information**	
Reference	**Name**	**Rhode Island Requirements**
PRV01	Rendering Provider Specialty Information	Populate with 'PE'
PRV02	Reference Identification Qualifier	Populate with 'PXC'
PRV03	Rendering Provider Taxonomy Code	Populate with Rendering Provider taxonomy Required when reporting a Rendering Providers NPI
Segment	**REF Rendering Provider Secondary Identification**	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers This field is required when submitting for an Atypical Rendering provider. This field should only be populated if the NPI is not present.
REF02	Reference Identification	Populate this field with the MMIS provider legacy ID (7 characters) that will be returned in the initial provider network exchange. The provider must come from an approved provider list for Atypical providers. *Note: If sending the rendering at the Header level, the rendering must be different from the Rendering in the 2420A Loop.*

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	**NM1 Service Facility Location Name**	
Reference	Name	Rhode Island Requirements
NM103	Name Last or Organization Name	Populate with Name Last or Organization Name. In the NM103 you can use the Last name or the Organization name. Example of 837P NM1*77*2*ABC CLINIC~ *Note: Please do not send the NM108 or NM109~*

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	N3 Service Facility Location Address	
Reference	Name	Rhode Island Requirements
N301	Address Information	Address information can be up to 55 bytes Example of 837P: N3*JOE JAY LANE~

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	N4 Service Facility Location City, State, Zip Code	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	Populate with City State and Zip. Report valid City, State and Zip information Example of 837P: N4*FORESTDALE*MA*026441109~

LOOP ID	2310C SERVICE FACILITY LOCATION NAME	
Segment	REF Service Facility Location Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'LU' Location Number
REF02	Reference Identification	This information is **Optional** for all claims. Populate with unique Location Number assigned by the health plan that links a provider to a specific location (which will be reported by the health plan in the MCO Provider Network file submission).This location code will link the rendering provider to the address where the actual service was performed. Example of 837P: REF*LU*1234567~

LOOP ID	2310E AMBULANCE PICK UP LOCATION	
Segment	**Individual or Organizational Name**	
Reference	**Name**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with "PW" This loop applies to Non-Emergency Transportation Brokers Only
NM102	Entity Type Qualifier	Populate with "2
Segment	**Ambulance Pick up Location Address**	
Reference	**Name**	**Rhode Island Requirements**
N301	Address Information	Pick up address line 1
N302	Address Information	Pick up address line 2 – if needed
Segment	**Ambulance Pick up Location City, State, Zip Code**	
Reference	**Name**	**Rhode Island Requirements**
N401	City Name	Pick Up City name
N402	State or Province Code	State Code
N403	Postal Code	Zip Code

LOOP ID	2310F AMBULANCE DROP OFF LOCATION	
Segment	**Individual or Organizational Name**	
Reference	**Name**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with "45" This loop applies to Non-Emergency Transportation Brokers Only
NM102	Entity Type Qualifier	Populate with "2"
Segment	**Ambulance Drop off Location Address**	
Reference	**Name**	**Rhode Island Requirements**
N301	Address Information	Drop off address line 1
N302	Address Information	Drop off address line 2 – if needed
Segment	**Ambulance Drop off Location City, State, Zip Code**	
Reference	**Name**	**Rhode Island Requirements**
N401	City Name	Drop off City name
N402	State or Province Code	State Code
N403	Postal Code	Zip Code

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	SBR Other Subscriber Information	
Reference	**Name**	**Rhode Island Requirements**
SBR01	Payer Responsibility Sequence Number Code	Health Plan should send in 'U'-Unknown for all iterations of this loop
SBR09	Claim Filing Indicator	**This information is required for all claims.** **Populate with 'MC' (Medicaid)** RI Medicaid also requires additional segments of the 2320 if any TPL information was factored into the Health Plan payment.

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	CAS Claim Level Adjustments	
CAS01	Claim Adjustment Group Code	At least one CAS segment is required for every claim. **The first occurrence will correspond to the Health Plan claim payment information, and any subsequent occurrences must correspond to any other insurance payments made on the claim.**

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	AMT Coordination of Benefits (COB) Payer Paid Amount	
Reference	**Name**	**Rhode Island Requirements**
AMT02	Payer Paid Amount	**This information is required for all claims.** **For the first occurrence, this element will always contain the Health Plan's paid amount on the claim. Zero "0" is an acceptable value for this element for fee for service paid claims.** **For claims covered under a capitated arrangement, the participating health plan MUST 'shadow price' the claim.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the amount paid by the other insurance carrier.** If the Other Insurance Paid Amounts (Loop 2320) are greater than the Claim Billed Amount, the claim will be rejected.

LOOP ID	2330A OTHER SUBSCRIBER NAME	
Segment	NM1 Other Subscriber Name	
Reference	**Name**	**Rhode Island Requirements**
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with 'MI'-Member Identification Number
NM109	Identification Code	The first occurrence should be the10 digit RI Medicaid Recipient Identification Number (MID) and for all subsequent occurrences, it should be the Other Insured Identifier Code. The 10-digit MID usage assumes post UHIP implementation; for claims submitted prior to UHIP, Phase 2, a 9-byte MID will be continued to be used.

LOOP ID	2330B OTHER PAYER NAME	
Segment	NM1 Other Payer Name	
Reference	**Name**	**Rhode Island Requirements**
NM109	Other Payer Primary Identifier	**This information is required for all claims.** **For the first occurrence, this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov.

LOOP ID	2330B OTHER PAYER NAME	
Segment	N3 Other Payer Address	
Reference	Name	Rhode Island Requirements
N301	Other Payer Address Line	**For the first occurrence, this element will always contain the Health Plan's address.** Address information can be up to 55 bytes.

LOOP ID	2330B OTHER PAYER NAME	
Segment	N4 Other Payer City, State, Zip Code	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	**For the first occurrence, this element will always contain the Health Plan's City State and Zip.**

LOOP ID	2330B OTHER PAYER NAME	
Segment	DTP Date-Claim Check or Remittance Date	
Reference	Name	Rhode Island Requirements
DTP03	Adjudication or Payment Date	**For the first occurrence, this element will always contain the Health Plan's payment date.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the payment date of the other insurance carrier.** *Note: The Header Paid date is ONLY required when the Health Plan is reporting Header only paid claims. If Reporting detail Paid claims DO NOT report Header paid date. (Reporting both dates will cause a compliance issue).* Rhode Island is expecting the Adjudication or Payment Date in CCYYMMDD format.

Detail of Claim

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**SV1 Professional Service**	
Reference	**Name**	**Rhode Island Requirements**
SV101-2	Procedure Code	Procedure code must be 5 characters or less. If this field contains more than 5 characters, the claim will be rejected.
Segment	**DTP- Service Date**	
DTP03	Date Time Period	Rhode Island is expecting the Service Date on the claim in CCYYMMDD or CCYYMMDD CCYYMMDD format.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**REF Prior Authorization**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Reference Identification	This is required if a **Prior Authorization Number** is present on the original claim.
Segment	**REF Line Item Control Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Line Item Control Number	If the Line Item Control Number if present on the original claim.
Segment	**REF Referral Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Prior Authorization or Referral Number	Populate with **Referral Number** if present on the original claim.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	HCP Claim Pricing/Repricing Information	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. ***Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.***
HCP02	Monetary Amount	Populate with allowed amount from health plan

LOOP ID	2410 DRUG IDENTIFICATION	
Segment	LIN Drug Identification	
Reference	**Name**	**Rhode Island Requirements**
LIN02	Product or Service ID Qualifier	Rhode Island is expecting the data to Populate with 'N4'- National Drug Code in 5-4-2 Format.
LIN03	National Drug Code	Rhode island is expecting the NDC that was submitted on the original claim to populate.

LOOP ID	2410 DRUG IDENTIFICATION	
Segment	CTP Drug Quantity	
Reference	**Name**	**Rhode Island Requirements**
CTP04	National Drug Unit Count	Rhode Island is expecting this field to populate with the quantity that was sent on the original claim.
CTP05-1	Unit or Basis For Measurement Code	Rhode island is expecting valid values: 'F2'- International Unit 'GR'= Gram 'ME'- Milligram 'ML'- Milliliter 'UN'= Unit

LOOP ID	2410 DRUG IDENTIFICATION	
Segment	REF Prescription or Compound Drug Association number	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Rhode Island is expecting valid values or : 'VY'- Link Sequence Number 'XZ'- Pharmacy Prescription Number *Note: RX qualifier and the Prescription/Link Number are not required if the provider is not sending in a compound drug.*
REF02	Prescription Number	Rhode Island is expecting Prescription Number or Link Sequence Number. *Note: RX qualifier and the Prescription/Link Number are not required if the provider is not sending in a compound drug.*

LOOP ID	2420 RENDERING PROVIDER NAME	
Segment	NM1 Rendering Provider Name	
Reference	Name	Rhode Island Requirements
NM103	Name Last Organization Name	Populate with Rendering Provider Last Name
NM108	Identification Code Qualifier	Populate with 'XX'

LOOP ID	2420A RENDERING PROVIDER NAME	
Segment	PRV Rendering Provider Specialty Information	
Reference	Name	Rhode Island Requirements
PRV01	Provider Code	Populate with 'PE'
PRV02	Reference Identification Qualifier	Populate with 'PXC'
PRV03	Reference Identification	Populate with Rendering Provider taxonomy This is required when reporting a Rendering Provider NPI.

LOOP ID	2420A RENDERING PROVIDER NAME	
Segment	REF Rendering Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers This field is required when submitting for an Atypical Rendering provider. This field should only be populated if the NPI is not present.
REF02	Rendering Provider Secondary Identifier	Populate this field with the MMIS provider legacy ID (7 characters) that will be returned in the initial provider network exchange. The provider must come from an approved provider list for Atypical providers. If sending the rendering at the detail level, the rendering must be different from the Rendering in the 2310B Loop.

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	SVD Line Adjudication Information	
Reference	Name	Rhode Island Requirements
SVD01	Identification Code	This is situational and to be used when reporting claims that are paid at the detail. **For Health Plan claims paid at the detail level, the first occurrence of this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code. When reporting this information, the number should match NM109 in Loop ID-2330B identifying Health Plan as the Other Payer.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer. Any additional other insurance carrier codes reported in this segment must be equal to NM109 in Loop 2330B identifying the other insurance carrier.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 35 of the 837 guide.*
SVD02	Monetary Amount	This is situational and to be used when reporting claims that are paid at the detail. If reporting payment information at the claim detail, the first occurrence should be the Amount that was paid by the Health Plan for the specific claim detail. Subsequent occurrences may contain other payer detail line adjustment information.

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	**CAS Line Adjustment**	
CAS01	Claim Adjustment Group Code	**This is required for any detail paid claims. The first occurrence should correspond to information related to the health plan's adjudication of the claim. Subsequent occurrences may contain other payer detail line adjustment information.**
LOOP ID	**2430 LINE ADJUDICATION INFORMATION**	
Segment	**DTP Line Adjudication Information**	
DTP03	Date Time Period	This is situational and to be used when reporting claims that are paid at the detail. **<u>If reporting payment information at the claim detail, the first occurrence should be the date the detail on the claim was paid by the Health Plan.</u>** The Detail Paid date is required when the Health Plan is reporting Detail paid claims. If Reporting detail Paid claims DO NOT report Header paid date. (Reporting both dates will cause a compliance issue). Populate with Adjudication or Payment date in CCYYMMDD format. *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 35 of the 837 guide*.

3.1 Table of Valid Type of Bill Code

*The Types of Bill listed below are for Encounter submissions only. The Fee for Service community has specific Types of Bill that are required for RI Medicaid to adjudicate correctly.

Type of Bill Used to Describe Hospital Record

Code Description

1st Digit: Submitting Facility

1 = Hospital

2 = Skilled Nursing

3 = Home Health

4 = Christian Science (Hospital)

5 = Christian Science (Extended Care)

6 = Intermediate Care

7 = Clinic*

8 = Special Facility*

9 = Other

**If Type of Facility - code 7 (clinic) is used,*
then the Bill Classification (clinics) - 2nd Digits must be used.

**If Type of Facility - code 8 (special facility) is used,*
then the Bill Classification (special facilities) - 2nd Digits must be used.

2nd Digit: Bill Classification (Except Clinics and Special Facilities)

1 = Inpatient (Including Medicare Part A)

2 = Inpatient (Medicare Part B only)

3 = Outpatient

4 = Other (for hospital referenced diagnostic services,
or home health not under a plan of treatment)**

5 = Intermediate Care-Level I

6 = Intermediate Care-Level II

7 = Intermediate Care-Level III

8 = Swing Beds

2nd Digit: Bill Classification (Clinics Only)

1 = Rural Health

2 = Hospital Based or Independent Renal Dialysis Center

3 = Free Standing

4 = Outpatient Rehabilitation Facility (ORF)

5 = Comprehensive Outpatient Rehabilitation Facilities (CORFs)

9 = Other

2nd Digit: Bill Classification (Special Facilities Only)

1 = Hospice (non-hospital based)

2 = Hospice (hospital based)

3 = Ambulatory Surgery Center

4 = Free Standing Birthing Center

9 = Other

3rd Digit: Frequency

1 = Admit through discharge date (one claim covers entire stay)

2 = First interim claim

3 = Continuing interim claim

4 = Last interim

7 = Replacement of prior claim

8 = Void/Cancel of prior claim

Clarification of the Bill Types has been formally agreed to the following, in order to categorize a claim as Inpatient or Outpatient.

Type of Bill	First Digit	Second Digit	Third Digit
Inpatient Claims	1,2,3,4,5,6,8,9	1,2,3,4,5,6,7,8	Any
Outpatient Claims	1,2,5,7,8	2,3,4,5,9	Any
Outpatient Claims *to be used as noted above	3,7,8	Any	Any

4. 005010X223A2 Health Care Claim: Institutional

PRE-HEADER		
Segment	**ISA Interchange Information**	
Reference	**Name**	**Rhode Island Requirements**
ISA01	Authorization Information Qualifier	Populate with ‘00’
ISA03	Security Information Qualifier	Populate with ‘00’
ISA05	Interchange ID qualifier	Populate with qualifier ‘ZZ’
ISA06	Interchange sender ID	Populate with Trading Partner ID assigned by RI Medicaid
ISA07	Interchange ID qualifier	Populate with ‘ZZ’
ISA08	Interchange Receiver ID	Use the RI EIN ‘056000522’
Segment	**GS Functional Group Header**	
Reference	**Name**	**Rhode Island Requirements**
GS02	Application Sender Code	Populate with Trading Partner ID assigned by RI Medicaid
GS03	Application Receiver Code	Populate with RI Medicaid EIN ‘056000522’
GS08	Version Identifier Code	Populate with ‘005010X223A2’

HEADER		
Segment	**ST Transaction Set Header**	
Reference	**Name**	**Rhode Island Requirements**
ST03	Implementation Convention Reference	Populate with '005010X223A2' **Page 2 Institutional Guide Section 1.3.2** "The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to higher limits. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA".
Segment	**BHT Beginning of Hierarchical Transaction**	
Reference	**Name**	**Rhode Island Requirements**
BHT06	Transaction Type Code	Populate with 'RP'-Reporting for Encounter transactions.

Note: Health Plans will continue to use their existing Trading Partner IDs to submit the new encounter claim utilization files. A unique Trading Partner already exists for each plan/program (i.e Rite Care, Rhody Health Partners, NHPRI ICI Phase 2, etc).

LOOP ID	1000A SUBMITTER NAME	
Segment	**NM1 Submitter Name**	
Reference	**Name**	**Rhode Island Requirements**
NM109	Submitter Identifier	Populate with Health Plan Trading Partner ID assigned by RI Medicaid
Segment	**PER Submitter EDI Contact Information**	
Reference	**Name**	**Rhode Island Requirements**
PER01	Submitter Identifier	RI Medicaid will only capture the information in the first PER segment (This would be the Health plan's contact information).

LOOP ID	1000B RECEIVER NAME	
Segment	**NM1 Receiver Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Receiver Name	Populate with 'RI Medicaid'
NM109	Identification code	Populate with RI Medicaid EIN '056000522'

LOOP ID	2000A BILLING PROVIDER	
Segment	PRV Billing Provider Specialty Information	
Reference	**Name**	**Rhode Island Requirements**
PRV01	Billing Provider Specialty Information	Populate with 'BI' (Billing Provider Code)
PRV02	Reference Identification Qualifier	Populate with 'PXC' (Taxonomy Code) qualifier)
PRV03	Provider Taxonomy Code	Populate with Billing Provider taxonomy. Required when reporting the Billing Provider NPI in Loop 2010AA

LOOP ID	2010AA Billing Provider Name	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	(Billing Provider's Last Name or Organization Name) This value corresponds to the billing provider name as reported on the original claim.
NM108	Identification Code Qualifier	Populate with 'XX**.** (To be blank if reporting atypical billing provider)

LOOP ID	2010AA Billing Provider Tax Identification	
Segment	**REF Billing Provider Secondary Identification**	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with billing provider's Tax ID information: EI = Employers Identification Number;
REF02	Reference Identification	Billing Provider's tax identification number

LOOP ID	2000B SUBSCRIBER HIERARCHICAL	
Segment	**HL Subscriber Hierarchical Level**	
Reference	**Name**	**Rhode Island Requirements**
HL04	Hierarchical Child Code	Populate with '0' The subscriber is the patient for all RI claims as per RI Medicaid claims submission standards.
Segment	**SBR Subscriber Information**	
Reference	**Name**	**Rhode Island Requirements**
SBR01	Payer Responsibility Sequence Number Code	Health Plans should send in any of the valid values of 'P'-Primary 'S'-Secondary or 'T'-Tertiary as to how the Health Plan is paying for the recipients payment
SBR09	Claim Filing Indicator	Populate with 'MC'

LOOP ID	2010BA SUBSCRIBER NAME	
Segment	**NM1 Subscriber Name**	
Reference	**Name**	**Rhode Island Requirements**
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with qualifier 'MI' (Member Identification Number)
NM109	Identification Code	Populate with the10 digit RI Medicaid Recipient Identification Number (MID) Encounter claims processing requires 10-digits for successful processing.

LOOP ID	2010 BB PAYER NAME	
Segment	NM1 Payer Name	
Reference	**Name**	**Rhode Island Requirements**
NM103	Name Last Organization Name	Populate with Name of the Health Plan
NM108	Identification Code Qualifier	Populate with 'PI'- Payor Identification
NM109	Identification Code	Populate with **Health Plan's Tax ID**

LOOP ID	2010 BB PAYER NAME	
Segment	REF Billing Provider Secondary Identification	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'G2' for Atypical providers ONLY in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan Do not populate this field for providers that have an NPI.
REF02	Payer Additional Identifier	This is the MMIS provider legacy ID (7 characters) that will be returned in the initial provider network exchange. The provider must come from an approved provider list for Atypical providers. This field is ONLY to be used in situations where the provider type (of the original Billing Provider) is considered to be atypical, based upon agreement between EOHHS and the Health Plan. Do not populate this field for providers that have an NPI. .

Header Section of claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	CLM Claim Information	
Reference	**Name**	**Rhode Island Requirements**
CLM01	Patient Account Information	RI will capture first 20 characters for encounter purposes
CLM02	Total Claim Charge Amt	Rhode Island is expecting the total claim charge amount in this field.
CLM05-3	Claim Frequency Code	The following is a list of the valid values contained within the 837 Institutional guide: 0 = Non-payment/zero claim 1 = Original 2 = First interim claim 3 = Continuing interim claim 4 = Last interim 5 = Late Charge(s) Only claim 6 = Adjustment of prior claim 7 = Replacement 8 = Void For reporting of new day claims, Health Plans should utilize a value of '1' indicating that this is an original claim. For the reporting of interim claims, Health Plans should utilize one of the following values: '2', '3' or '4'. For any claim replacement or claim void, the Health Plan must utilize a value of '7' (to denote a claim replacement) or '8' (Claim Void) in order to trigger the MMIS claim adjustment processing. *Please see Adjustment document for adjustment examples.*

LOOP ID	2300 CLAIM INFORMATION	
Segment	DTP Date-Admission Date/Hour	
Reference	Name	Rhode Island Requirements
DTP01	Date Time Qualifier	This information is required for inpatient claims only. Rhode Island is expecting this to Populate with qualifier '435'- Admission.
DTP02	Date Time Period Format Qualifier	Rhode Island is expecting the qualifier 'DT'- Date and Time qualifier.
DTP03	Date Time Period	Rhode Island is expecting Admission Date and Time, inCCYYMMDDHHMM format if present and used on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	CL1 Institutional Claim Code	
Reference	Name	Rhode Island Requirements
CL101	Admission Type Code	Populate with '1'-Emergency, '2'-Urgent, '3'-Elective, or '4'-Newborn for all Inpatient Services

LOOP ID	2300 CLAIM INFORMATION	
Segment	CN1 Contract Information	
Reference	Name	Rhode Island Requirements
CN101	Contract Type Code	This is required if the service rendered was part of an existing sub-capitated arrangement between the health plan and the billing provider. Populate with '05' (Capitated) for services rendered as part of a sub-capitated arrangement.

LOOP ID	2300 CLAIM INFORMATION	
Segment	REF Referral Number	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with "9F" (Referral number)
REF02	Prior Authorization or Referral Number	Populate with **Referral Number** if present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**REF Prior Authorization**	
Reference	**Name**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with "G1" (Prior Authorization Number)
REF02	Prior Authorization Number	This is required if **Prior Authorization Number** is present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**REF Payer Claim Control Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Payer Claim Control Number	This information is required. The Payer claim control number is the health plan's original ICN. This should be sent on all claims. To initiate adjustments or voids, the payer claim control number should be sent with a claim frequency type code (CLM05-3) of '7'-(Adjustment) or '8'-(Void). ***Note—When submitting a claim adjustment, Health Plan should always use the original claim identifier assigned by the adjudicating health plan assigned to the original paid claim as reported and applied to the MMIS.***

LOOP ID	2300 CLAIM INFORMATION	
Segment	HI Principal Diagnosis	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Code List Qualifier Code	Populate with 'BK' for submission of ICD-9 codes or 'ABK' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI01-2	Principal Diagnosis Code	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
H101-9	Present on Admission Indicator	This must be sent by the Health Plans if Present on Admission indicator was present on the original claim.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI Admitting Diagnosis**	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Code List Qualifier Code	Populate with 'BJ' for submission of ICD-9 codes or 'ABJ' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI01-2	Industry Code	This value would be the admitting diagnosis code. Populate with applicable ICD-9 or ICD-10 code. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
Segment	**HI Patient's Reason for Visit**	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through HI2)-1	Diagnosis Type Code	Populate with 'PR' for submission of ICD-9 codes or 'APR' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI01 through HI2)-2	Patient Reason for Visit	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
Segment	**HI External Cause of Injury**	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through HI12) - 1	Diagnosis Type Code	Populate with 'BN' for submission of ICD-9 codes or 'ABN' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI External Cause of Injury**	
(HI01 through HI12) - 2	External Cause of Injury Code	Populate with applicable ICD-9 or ICD-10 code. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI01 through HI12)-9	Present on Admission Indicator	This must be sent by the Health Plans if Present on Admission indicator was present and used on the original claim.
Segment	**HI Diagnosis Related Group (DRG) Information**	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Qualifier	Populate with 'DR' (Diagnosis Related Group (DRG)
HI01-2	DRG Code	Diagnosis Related Group Number Required for Inpatient Hospital claims
Segment	**HI Other Diagnosis Information**	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through HI12) - 1	Diagnosis Type Code	Populate with 'BF' for submission of ICD-9 codes or 'ABF' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI01 through HI12) - 2	Other Diagnosis	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI01 through HI12) -9	Present on Admission Indicator	This must be sent by the Health Plans if Present on Admission indicator was present on the original claim

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI Principal Procedure Information**	
Reference	**Name**	**Rhode Island Requirements**
HI01-1	Qualifier	Populate with 'BR' for submission of ICD-9 codes or 'BBR' for submission of ICD-10 codes. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
HI01-2	Principal Procedure Code	Populate with applicable ICD-9 or ICD-10 code. A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI Other Procedure Information**	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through HI12) - 1	Qualifier Code	Populate with 'BQ' for submission of ICD-9 codes or 'BBQ' for submission of ICD-10 codes A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.
(HI01 through HI12) - 2	Procedure Code	Populate with applicable ICD-9 or ICD-10 code A claim with a mixture of ICD-9 and ICD-10 codes will pass compliance, however, it will deny when processed in MMIS.

LOOP ID	2300 CLAIM INFORMATION	
Segment	HI Occurrence Information	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through HI12)-1	Qualifier	Populate with “BH” (Occurrence) (Health Plan must send if present on the original claim)
(HI01 through H12)-2	Occurrence Code	Occurrence code associated with the claim, if applicable (Health Plan must send if present on the original claim)
(HI01 through H12)-3	Date Time Period Format Qualifier	Populate with “D8” (Health Plan must send if present on the original claim)
(HI01 through H12)-4	Date Time Period	Occurrence Code Date CCYYMMDD format. (Health Plan must send if present on the original claim)

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HI Treatment Code Information**	
Reference	**Name**	**Rhode Island Requirements**
(HI01 through H12)-1	Qualifier	Discuss further with EOHHS to determine if information within the HI Segment is needed Populate with "TC" (Treatment Code) (Health Plan must send if present on the original claim)
(HI01 through H12)-2	Treatment Code	Treatment Code (Health Plan must send if present on the original claim)

LOOP ID	2300 CLAIM INFORMATION	
Segment	**HCP Claim Pricing/Repricing Information**	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. ***Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.***
HCP02	Repriced Allowed Amount	Populate with allowed amount from health plan

LOOP ID	2310A ATTENDING PROVIDER NAME	
Segment	**NM1 Attending Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
NM103	Last or Organization name	Populate with Attending Provider's Last Name (Health Plan must send if used to adjudicate the claim)
NM108	Identification Code Qualifier	Populate with 'XX' (NPI) (Health Plan must send if present on the original claim)

LOOP ID	2310A ATTENDING PROVIDER NAME	
Segment	PRV Attending Provider Specialty Information	
Reference	Name	Rhode Island Requirements
PRV01	Attending Provider Specialty Information	Populate with 'AT' (Attending Provider Code)
PRV02	Reference Identification Qualifier	Populate with 'PXC' (Taxonomy Code qualifier)
PRV03	Provider Taxonomy Code	Populate with Attending Provider's taxonomy if it is available and was reported on the original claim

LOOP ID	2310E SERVICE FACILITY LOCATION NAME	
Segment	NM1 Service Facility Location Name	
Reference	Name	Rhode Island Requirements
NM103	Name Last or Organization Name	Populate with Name Last or Organization Name In the NM103 you can use the Last name or the Organization name. Example of 837I NM1*77*2*ABC CLINIC~ *Note:Please do not send the NM108 or NM109~*

LOOP ID	2310E SERVICE FACILITY LOCATION NAME	
Segment	N3 Service Facility Location Address	
Reference	Name	Rhode Island Requirements
N301	Address Information	Address information can be up to 55 bytes Example of 837I: N3*JOE JAY LANE~

LOOP ID	2310E SERVICE FACILITY LOCATION NAME	
Segment	N4 Service Facility Location City, State, Zip Code	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	Populate with City State and Zip. Report valid City, State and Zip information Example of 837I: N4*FORESTDALE*MA*026441109~

LOOP ID	2310E SERVICE FACILITY LOCATION NAME	
Segment	REF Service Facility Location Secondary Identification	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with 'LU' Location Number
REF02	Laboratory of Facility Secondary Identifier	This information is **Optional** for all claims. Populate with unique Location Number assigned by the health plan that links a provider to a specific location (which will be reported by the health plan in the MCO Provider Network file submission) This location code will link the rendering provider to the address where the actual service was performed. Example of 837I: REF*LU*1234567~

LOOP ID	2310F REFERRING PROVIDER NAME	
Segment	NM1 Referring Provider Name	
Reference	Name	Rhode Island Requirements
NM101	Entity Identifier Code	Populate with "DN" (Referring Provider) (Health Plan must send present and used on the original claim)
NM108	Identification Code Qualifier	Populate with "XX" (Health Plan must send present and used on the original claim)
NM109	Referring Provider Identifier	Referring Provider NPI (Health Plan must send if present on the original claim)

LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	SBR Other Subscriber Information	
Reference	Name	Rhode Island Requirements
SBR01	Payer Responsibility Sequence Number Code	Health Plan should send in 'U'-Unknown for all iterations of this loop
SBR09	Claim Filing Indicator	**This information is required for all claims. Populate with 'MC' (Medicaid)** RI Medicaid also requires additional segments of the 2320 if any TPL information was factored into the Health Plan
LOOP ID	2320 OTHER SUBSCRIBER INFORMATION	
Segment	CAS Claim Level Adjustments	
CAS01	Claim Adjustment Group Code	At least one CAS segment is required for every claim. **The first occurrence will correspond to the Health Plan claim payment information, and any subsequent occurrences must correspond to any other insurance payments made on the claim.**
Segment	AMT Coordination of Benefits (COB) Payer Paid Amount	
Reference	Name	Rhode Island Requirements
AMT02	Payer Paid Amount	**This information is required for all claims.** **For the first occurrence, this element will always contain the Health Plan's paid amount on the claim. Zero "0" is an acceptable value for this element for fee for service paid claims. When reporting health plans paid amount or OI you only need to report this information at the header. Reporting only one (1) AMT segment for the claim.** **For claims covered under a capitated arrangement, the participating health plan MUST 'shadow price' the claim.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the amount paid by the other insurance carrier.** If the Other Insurance Paid Amounts (Loop 2320) are greater than the Claim Billed Amount, the claim will be rejected

LOOP ID	2330A OTHER SUBSCRIBER NAME	
Segment	NM1 Other Subscriber Name	
Reference	Name	Rhode Island Requirements
NM102	Entity Type Qualifier	Populate with '1' for person
NM108	Identification Code Qualifier	Populate with 'MI'-Member Identification Number
NM109	Identification Code	The first occurrence should be the 10 digit RI Medicaid Recipient Identification Number (MID) and for all subsequent occurrences, it should be the Other Insured Identifier Code. The 10-digit MID usage assumes post UHIP implementation; for claims submitted prior to UHIP, Phase 2, a 9-byte MID will be continued to be used.

LOOP ID	2330B OTHER PAYER NAME	
Segment	NM1 Other Payer Name	
Reference	Name	Rhode Island Requirements
NM109	Other Payer Primary Identifier	**This information is required for all claims.** **For the first occurrence, this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov.

LOOP ID	2330B OTHER PAYER NAME	
Segment	N3 Other Payer Address	
Reference	Name	Rhode Island Requirements
N301	Other Payer Address Line	**For the first occurrence, this element will always contain the Health Plan's address.** Address information can be up to 55 bytes

LOOP ID	2330B OTHER PAYER NAME	
Segment	N4 Other Payer City, State, Zip Code	
Reference	Name	Rhode Island Requirements
N401	Other Payer City Name	**For the first occurrence, this element will always contain the Health Plan's City State and Zip.** If reporting other insurance City State and Zip report valid City, State and Zip information

LOOP ID	2330B OTHER PAYER NAME	
Segment	DTP Date-Claim Check or Remittance Date	
Reference	Name	Rhode Island Requirements
DTP03	Adjudication or Payment Date	**For the first occurrence, this element will always contain the Health Plan's payment date.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the payment date of the other insurance carrier.** *Note: The Header Paid date is ONLY required when the Health Plan is reporting Header only paid claims. If Reporting detail Paid claims DO NOT report Header paid date. (Reporting both dates will cause a compliance issue).* Rhode Island is expecting the Adjudication or Payment Date in CCYYMMDD format

Detail of Claim

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**SV2 Institutional Service Line**	
Reference	**Name**	**Rhode Island Requirements**
SV201	Service Line Revenue Code	Populate with revenue code that is four characters or less or the claim will be rejected. Right justified zero fill if necessary
SV202-1	Product or Service ID Qualifier	Populate with "HC"- HCPCS Code
SV202-2	HCPCS Code	A field containing more than 5 characters will cause the claim to reject.
Segment	**DTP-Date Service Date**	
DTP03	Date Time Period	Rhode Island is expecting the Service Date on the claim in CCYYMMDD or CCYYMMDD CCYYMMDD format
Segment	**REF Line Item Control Number**	
Reference	**Name**	**Rhode Island Requirements**
REF02	Line Item Control Number	If the Line Item Control Number is available, send the information that was reported on the original claim.

LOOP ID	2400 SERVICE LINE NUMBER	
Segment	**HCP Line Pricing/Repricing Information**	
Reference	**Name**	**Rhode Island Requirements**
HCP01	Pricing Methodology	Rhode Island will take in ALL of the valid qualifiers reported in this segment. Health plans should use the qualifier as appropriate for the reimbursement type. ***Note: Rhode Island will expect the Health plans to use the '04'-Bundled Pricing qualifier when reporting bundled services.***
HCP02	Repriced Allowed Amount	Populate with allowed amount from health plan

LOOP ID	2410 DRUG IDENTIFICATION	
Segment	LIN Drug Identification	
Reference	Name	Rhode Island Requirements
LIN02	Product or Service ID Qualifier	Rhode Island is expecting the data to Populate with 'N4'- National Drug Code in 5-4-2 Format
LIN03	National Drug Code	Rhode island is expecting the NDC that was submitted on the original claim to populate
LOOP ID	2410 DRUG IDENTIFICATION	
Segment	CTP Drug Quantity	
Reference	Name	Rhode Island Requirements
CTP04	National Drug Unit Count	Rhode Island is expecting this field to populate with the quantity that was sent on the original claim.
CTP05-1	Unit or Basis For Measurement Code	Rhode island is expecting valid values: 'F2'- International Unit 'GR'= Gram 'ME'- Milligram 'ML'- Milliliter 'UN'= Unit

LOOP ID	2410 DRUG IDENTIFICATION	
Segment	REF Prescription or Compound Drug Association number	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Rhode Island is expecting valid values or : 'VY'- Link Sequence Number 'XZ'- Pharmacy Prescription Number *Note: RX qualifier and the Prescription/Link Number are not required if the provider is not sending in a compound drug.*
REF02	Prescription Number	Rhode Island is expecting Prescription Number or Link Sequence Number. *Note: RX qualifier and the Prescription/Link Number are not required if the provider is not sending in a compound drug.*

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	SVD Line Adjudication Information	
Reference	**Name**	**Rhode Island Requirements**
SVD01	Other Payer Primary Identifier	This is situational and to be used when reporting claims that are paid at the detail. **For Health Plan claims paid at the detail level, the first occurrence of this element will always contain the Health Plan's three byte RIMA Insurance Carrier Code. When reporting this information, the number should match NM109 in Loop ID-2330B identifying Health Plan as the Other Payer.** **If other insurance payments were factored into a claim, subsequent occurrences of this element are to contain the three byte insurance carrier code associated with the other TPL payer. Any additional other insurance carrier codes reported in this segment must be equal to NM109 in Loop 2330B identifying the other insurance carrier.** Sending more than 3 characters will cause the claim to reject. Each carrier code used must be unique within the current claim. A complete list of Carrier Codes can be found at www.eohhs.ri.gov. *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 35 of the 837 guide.*
SVD02	Monetary Amount	This is situational and to be used when reporting claims that are paid at the detail. If reporting payment information at the claim detail, the first occurrence should be the Amount that was paid by the Health Plan for the specific claim detail. Subsequent occurrences may contain other payer detail line adjustment information.

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	**CAS Line Adjustment**	
CAS01	Claim Adjustment Group Code	**This is required for any detail paid claims. The first occurrence should correspond to information related to the health plan's adjudication of the claim. Subsequent occurrences may contain other payer detail line adjustment information.**

LOOP ID	2430 LINE ADJUDICATION INFORMATION	
Segment	**DTP Line Check or Remittance Date**	
DTP03	Adjudication or Payment Date	This is situational and to be used when reporting claims that are paid at the detail. The Detail Paid date is required when the Health Plan is reporting Detail paid claims. If Reporting detail Paid claims DO NOT report Header paid date. (Reporting both dates will cause a compliance issue). **If reporting payment information at the claim detail, the first occurrence should be the date the detail on the claim was paid by the Health Plan.** Populate with Adjudication or Payment date in CCYYMMDD format. *Note: The Amount reported in the below fields below must conform to the formulas outlined on page 35 of the 837 guide*.

5. Appendix A

The following ACK, 999, SUB and TA1 examples were generated for Fee for Service 837 claim submissions, which conform to the X12 5010 HIPAA standard. These reports are generated from the translator software used by RI Medicaid and are not being modified as part of this project. Additional information specific to these transactions can be found in the 837 Institutional, Professional, and Dental guides.

'ACK' Report: This provides a 'readable' version of the contents of the 999 acknowledgement file, represented on report RI999ACK.

Example ACKNOWLEDGEMENT (ACK)

```
RI999ACK                      RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM            PAGE 999999


RUN DATE: MM/DD/CCYY 11:03           999 FUNCTIONAL ACKNOWLEDGEMENT REPORT


TRANSLATION DATA:
File Sak: 31510        File Name: 000000031510.130206000000 Map Release: M11.03v01 Map Name: XRI_999_5010_REPORT


INTERCHANGE DATA:                    FUNCTIONAL GROUP DATA:                TRANSACTION SET DATA:
Control Number : 000000593           Control Number : 256                  Control Number : 256001
Date-Time      : 20130206-110300     Date-Time      : 20130206-11033122
Receiver ID    : 999999999            Receiver ID    : 999999999
Sender ID      : 999999999           Sender ID      : 999999999

TRANSACTION SET ACCEPT/REJECT:

Accept/Reject  : R-Rejected          Control Number : 000000001            Identifier     : 837
Code: I5  - Implementation One or More Segments in Error
Segment: SBR      Count:         27  Loop: 2320 -Segment Has Data Element Errors
Element:   5  Component:             Code:    7 -Invalid code value.
Value: OT

FUNCTIONAL GROUP ACCEPT/REJECT:

Accept/Reject  : R-Rejected          Control Number : 714                  Identifier     : HC
Txns Included  : 1                   Txns Received  : 1                    Txns Accepted  : 0

                                                * * E N D   O F   R E P O R T * *
```


Example 999

```
ISA*00*          *00*          *ZZ*999999999      *ZZ*999999999
*130206*1106*^*00501*000000594*0*P*:~GS*FA*999999999*999999999*20130206*11061850*257*X*005010X231A1~ST*999*257001*005010X231A1~AK1*HC*715*005010X222A
1~AK2*837*000000001*005010X222A1~IK5*A~AK9*A*1*1*1~SE*6*257001~GE*1*257~IEA*1*000000594~
```

SUB / Claim Accept/Reject

Example of SUB

```
CLAR230P                                RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE 999999

RUN DATE: MM/DD/CCYY 13:03                CLAIM ACCEPT / REJECT REPORT - 837 PROFESSIONAL

INTERCHANGE DATA:                     FUNCTIONAL GROUP DATA:                TRANSLATION DATA:
  Control Number : 000000999            Control Number : 999                  File SAK       : 99999
  Date-Time      : 20130206-140300      Date-Time      : 20130206-1403        File Name      : good1165516.edi
  Receiver ID    : 999999999            Receiver ID    : 999999999            Map Name       : XRI_837PI_5010_A1
  Sender ID      : 999999999            Sender ID      : 999999999            Map Release    : M11.03v01

TRANSACTION SET DATA:
  Control Number : 000000001
  Date-Time      : 20130206-140300
  Ver/Rel/Ind Co : 005010X222A1


  BILLING PROVIDER:
     Identifier     : 9999999999
     Last/Org Name  : PROVIDER NAME HERE

    CLM SEQ #  REJECTED CLAIM INFORMATION:
    ---------  ------------------------------------------------------------------------------------------------------------------------
    000000002  PAT ACCT NUM: TESTCASE NUMBER 1
                   Loop/Element: 2400 SV101-1            Element Value: TC
                  Code: E1021        Element Info: 2400 SV101-1
                Message: Product/Service ID Qualifier must contain a value of 'HC'.

                ........................................................................................................................

       Claims Rejected: 000000001


TRANSACTION SET PROCESSING TOTALS:

          Claims Received: 000000002     Claims Rejected: 000000001     Claims Accepted: 000000001

                                              * *  E N D   O F   R E P O R T  * *
```

Example of TA1


```
601100042/OUT/000000341476.130208000000.TA1

ISA*00*          *00*          *ZZ*999999999      *ZZ*999999999      *130208*1212*^*00501*000000022*0*P*:~
TA1*000000019*130208*1103*A*000~
IEA*0*000000022~
```


6. Appendix B

Examples of a Rhode Island Business Rule:

If claim is submitted as follows:

If claim is submitted as follows:

SV101-1 value must be equal to HC on each claim detail received. The following business rule applies.

Code: E1021
Element Info: 2400 SV101-1
Message: Product/Service ID Qualifier must contain a value of 'HC'.

Executive Office of Health and Human Services

Hewlett Packard Enterprise

STANDARD COMPANION GUIDE TRANSACTION INFORMATION

RHODE ISLAND MEDICAID

Instructions related to 834 HIPAA Compliant Transactions based on ASC X12 Implementation Guide-Transportation Broker

Version 1.5

Hewlett Packard Enterprise

Revision History

VERSION	DATE	SECTION REVISED	REASON FOR REVISION
1.0	9.2014	Newly Created	
1.1	3.25.15	Various sections	MID for UHIP
1.2	5.13.15	Various sections	MID UHIP
1.3	5.18.15	Various sections	Reverse of MID changes UHIP
1.4	11.01.15	Logo, title page	HPE name change
1.5	02.12.16	Page 6, 7, and 8	Loop 2100B added, prior MID added in loop 2000, and some other missing UHIP changes

Table of Contents

1. 834 Benefit Enrollments and Maintenance Transaction..... 4
1.1. LogistiCare Roster and Payment File..... 4

1. 834 Benefit Enrollments and Maintenance Transaction

This transaction will be used by RI Medicaid to transmit bi-monthly after each of the two premium payment financial cycles.

The first 834 to LogistiCare would be a full roster file containing all per member per month premium payments for the prospective month, and may contain any adjustments for the current or previous months. This is similar to the Rhody Health Partners and Rhody Health Options schedule and would be generated in the first premium payment financial each month.

The second 834 file to LogistiCare would be generated in the second premium payment financial each month, and would only contain any adds, updates, end dates, pay level change or cancels that were entered since the first premium payment financial cycle of the month. This is commonly referred to as the adjustment file

This transaction is use exclusively to support the Transportation Broker Program and is exchanged between RI Medicaid and LogistiCare.

These specifications are to be used in conjunction with the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3. These reports can be obtained from the Washington Publishing Company at www.wpi-edi.com. This RI Medicaid Companion Guide provides supplemental information specific to the exchange of recipient enrollment and payment information between RI Medicaid and the contracted Transportation Broker as permitted within the HIPAA transaction sets. Specifications may be updated as necessary.

005010X220A1 834 Transaction

1.1. LogistiCare Roster and Payment File

LOOP D	**HEADER**	
Segment	**BGN Beginning Segment**	
Reference	**Name**	**Rhode Island Requirements**
BGN01	Transaction Set Purpose	Populate with ‘00’ (first transaction sent)
BGN02	Transaction Reference Identification	Populate with the Payment Run Date, in format ccyymmdd.
BGN08	Action Code	Populate with ‘2’ for change or ‘4’ for verify (full payment file). Note –A value of ‘4’ will be populated in the LogistiCare Payment file (the first file sent every month); a value of ‘2’ will be populated for the Change/Adjustment file (the second 834 sent in the latter half of every month).

LOOP ID	1000A SPONSOR NAME	
Segment	N1 Sponsor Name	
Reference	Name	Rhode Island Requirements
N102	Name	Populate with 'Rhode Island Medicaid Management Information System'.
N103	Identification Code Qualifier	Populate with 'FI'(Federal Tax Identification)
N104	Identification Code	Populate with '05-6000522'
LOOP ID	1000B PAYER	
Segment	N1 Payer	
Reference	Name	Rhode Island Requirements
N102	Name	Populate with the LogistiCare (Transportation Broker Name receiving the 834.)
N103	Identification Code Qualifier	Populate with 'FI'.
N104	Insurers Identification code	Populate with FEIN associated with the health plan receiving the 834. (This is the FEIN# specified by LogistiCare in their provider enrollment documentation.)
LOOP ID	1000C TPA/BROKER NAME	
Segment	N1 TPA/Broker Name	
Reference	Name	Rhode Island Requirements
N101	Entity Identifier Code	Populate with 'TV' (Third Party Administrator)
N102	Name	Populate with 'HP
N103	Identification Code Qualifier	Populate with 'FI'
N104	TPA or Broker Identification Code	Populate with '75-2548221'
LOOP ID	2000 MEMBER LEVEL DETAIL	
Segment	INS Member Level Detail	
Reference	Names	Rhode Island Requirements
INS01	Subscriber Indicator	Populate with 'Y' (Yes)
INS02	Individual Relationship Code	Populate with '18' (Self)
INS03	Maintenance Type Code	Populate with '001' or '30' Note –A value of '030' will be populated in the LogistiCare Payment file (the first file sent in the first half of every month), and a value of '001' will be populated for the LogistiCare Change/Adjustment file (the second 834 sent in the latter half of every month).
INS04	Maintenance Reason Code	Populate with 'XN (Notification Only)

INS05	Benefit Status Code	Populate with 'A' (Active)
INS08	Employment Status Code	Populate with 'FT' (Full Time)

Segment	**REF Subscriber Identifier**	
Reference	**Names**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with '0F' (Subscriber Number)
REF02	Subscriber Identifier	Populate with RI MMIS Recipient Unique ID (RUI). Note: RUI is a value RI MMIS generates unique to recipient and is a link between any temporary and permanent MID assigned to a given recipient.
Segment	**Member Supplemental Identifier – can possibly repeat 2 times**	
Reference	**Names**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'Q4'
REF02	Reference Identification	Populate with 'Prior Medicaid Identification number (MID), if one exists. This field could potentially be 9 characters during a transitional time period. Once the conversion is complete this field will be 10 characters
Segment	**Member Supplemental Identifier**	
Reference	**Names**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	RI Medicaid expects "ZZ"
REF02	Reference Identification	Populate with Populate with Subscriber Social Security Number
LOOP ID	**2100A MEMBER NAME**	
Segment	**NM1 Member Name**	
Reference	**Names**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with 'IL' (Insurer)
NM103	Name Last Organization	Populate with 'last name' (maximum of 30 characters)
NM104	Name First	Populate with 'first name' (maximum of 30 characters)
NM105	Name Middle	Populate with 'middle initial or middle name' (25 character)

NM107	Suffix	Populate with 'suffix' (maximum of 4 characters)
NM108	Identification Code Qualifier	Populate with 'ZZ(Mutually Defined)
NM109	Identification Code	Populate with 10 character MMIS Medicaid Identification Number
LOOP ID	**2100A MEMBER NAME**	
Segment	**PER Member Communications Numbers**	
Reference	**Names**	**Rhode Island Requirements**
PER01	Contact Function Code	Populate with 'IP'
PER03	Communication Number Qualifier	Populate with 'TE'
PER04	Communication Number	Populate with '10 character member telephone number' (1 of 2)
PER05	Communication Qualifier	Populate with 'TE'
PER06	Communication Number	Populate with '10 character member telephone number' (2 of 2)
PER07	Communication Number Qualifier	Populate with 'TE'
PER08	Communication Number	Populate with 'Phone Number 3 + comment #3'
Segment	**N3 Member Residence Street Address**	
Reference	**Names**	**Rhode Island Requirements**
N301	Address Information	Populate with recipient address maximum 30 characters
N302	Address Information	Populate with additional address information if exists maximum 55 characters
Segment	**N4 Member City, State, ZIP Code**	
Reference	**Names**	**Rhode Island Requirements**
N401	City Name	Populate with recipient city maximum 25 characters
N402	State or Province Code	Populate with recipient state
N403	Postal Code	Populate with recipient zip
N405	Location Qualifier	Populate with 'CY' (County)
N406	Location Identifier	Populate with record location (2 char) ***Note: This is mailing address and not member's resident address.**
Segment	**DMG Member Demographics**	
Reference	**Names**	**Rhode Island Requirements**
DMG01	Date Format Qualifier	Populate with 'D8' (ccyymmdd)
DMG02	Member Birth Date	Populate with 'Recipient Birth Date' (format ccyymmdd-20140118)
DMG03	Gender Code	Populate with 'Gender Code' (M or F)

DMG05	Race or Ethnicity Code	Populate with Recipient Race Code'
Segment	**LUI Member Language**	
Reference	**Names**	**Rhode Island Requirements**
LUI01	Identification Code Qualifier	Populate with 'LE'(Language Code)
LUI02	Language Code	Populate with 'language code'
LOOP ID	**2100B INDIVIDUAL OR ORGANIZATIONAL NAME**	
Segment	**NM1 INCORRECT MEMBER NAME** This is a situational loop that will only be sent when a recipient has had a change to their Social Security Number (SSN) and thus their old (prior) SSN needs to be sent. A recipient's prior SSN will only be sent one time.	
Reference	**Names**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with '70'
NM102	Entity Type Qualifier	Populate with '1'
NM103	Name Last or Organization Name	Populate with Recipient Last Name maximum 30 characters
NM104	Name First	Populate with Recipient First Name maximum 30 characters
NM105	Name Middle	Populate with Recipient Middle Initial or Middle Name maximum 25 characters
NM107	Name Suffix	Populate with Recipient Name Suffix maximum 4 characters
NM108	Identification Code Qualifier	Populate with 'ZZ'
NM109	Identification Code	Populate with recipient's prior SSN
LOOP ID	**2100G RESPONSIBLE PERSON**	
Segment	**NM1 Responsible Person**	
Reference	**Names**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with 'QD' (Responsible party)
NM103	Responsible Party Name Last or Organization	Populate with 'HOH Last Name' (maximum of 30 characters)
NM104	Responsible Party Name First	Populate with 'HOH First Name' (maximum of 30 characters)
NM105	Responsible Party Name Middle	Populate with 'HOH Middle Initial or middle name' maximum 25 characters
NM107	Responsible Party Name Suffix	Populate with 'HOH Modifier' (maximum of 4 characters)

LOOP ID	2300 HEALTH COVERAGE	
Segment	HD Health Coverage	
Reference	Names	Rhode Island Requirements
HD01	Maintenance Type Code	Populate with '030' for full roster (LogistiCare Payment file, first financial cycle of each month only). Populate with '021' for additions (LogistiCare Adjustment file, second financial cycle of each month only). Populate '024' for enrollment terminations (LogistiCare Adjustment file only)
HD03	Insurance Line Code	Populate with 'HMO'
HD04	Plan Coverage Description	Populate with Pay level code. (For example, TB01-Rite Care, TB02-Aged/Blind/Disabled and TB03-CNOM)
Segment	DTP Health Coverage Dates	
Reference	Names	Rhode Island Requirements
DTP01	Date/Time Qualifier	Populate with '348' (Benefit Begin)
DTP02	Date Time Period Format	Populate with 'D8'
DTP03	Date Time Period	RI will use format 'ccyymmdd' to represent the start date of monthly premium the payment period.
Segment	AMT Health Coverage Policy	
Reference	Names	Rhode Island Requirements
AMT01	Amount Qualifier Code	Populate with 'P3' (Premium Amount)
AMT02	Monetary Amount	Populate with payment amount for period reported in DTP Health coverage segment. (format 9999999.99).
LOOP ID	2300 HEALTH COVERAGE	
Segment	REF Health Coverage Policy Number	
Reference	Names	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with '1L' (Group or Policy)
REF02	Reference Identification	Populate with 'MMIS Policy Number' For Example-Policy number will begin with TMP followed by numbers.
LOOP ID	2310 PROVIDER INFORMATION	
Segment	LX Provider Information	
Reference	Name	Rhode Island Requirements
LX01	Assigned Number	Assigned Number. As stated in the ASC X12 Transaction Broker guide for the 834 Benefit Enrollment and Maintenance, this value is 'a

		sequential number representing the number of loops for the insured person."
Segment	**NM1 Provider Name**	
Reference	**Name**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with 'P3' (Primary Care Provider).
NM102	Entity Type Qualifier	Populate with '2' (Non Person).
NM103	Name Last or Organization Name	Populate with 'Primary Care Physician Name, (if information exists on the MMIS).
NM110	Entity Relationship Code	Populate with '72' (Unknown).
LOOP ID	**2320 COORDINATION OF BENEFITS**	
Segment	**COB Coordination of Benefits**	
Reference	**Names**	**Rhode Island Requirements**
COB01	Payer Responsibility Sequence Number Code	Populate with U (Unknown)
COB02	Reference Identification	Populate with '1' for Third Party Liability Policy Number (16 Characters)
COB03	Coordination of Benefits Code	Populate with '1' for Coordination of Benefits or '5' for Unknown and '6' **No Coordination of Benefits-this is used for Managed Care**
Segment	**REF Additional Coordination of Benefits Identifiers**	
Reference	**Names**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate 60, 6P, SY, ZZ Note: This is based on values on TPL table, For example- Qualifier 60 is for Court Order; 6P for Coverage Type; SY for SSN and ZZ for Relationship code. Manage Care Health Plan will always populate with ZZ.
REF02	Reference Identification	Populate with 'Court Order Indicator' (1 character), 'Coverage Type' (2 characters), 'Relationship Code' (3 characters) or 'Policyholder SSN' (9 characters), depending on value of qualifier in REF01. For example, if Court Order-indicator will be Y/N; Coverage Type will RH,E1, D1 etc. -
Segment	**DTP Coordination of Benefits Eligibility Dates**	
Reference	**Names**	**Rhode Island Requirements**
DTP01	Date Time Qualifier	Populate with '344'-- Coordination of Benefits Begins and '345' -- Coordination of Benefits End (End date will be 12/31/2382) Note: Any verified TPL in effect as of the Run Date will be reported on the 834. No future TPL start date will be reported.

DTP02	Date Time Format Qualifier	Populate with 'D8' (CCYYMMDD)
DTP03	Date Time Period	RI will use format 'ccyymmdd' to represent the start and stop dates of the coverage period
LOOP ID	**2330 COORDINATION OF BENEFITS RELATED ENTITY**	
Segment	**NM1 Coordination of Benefits Related Entity**	
Reference	**Names**	**Rhode Island Requirements**
NM101	Entity Identifier Code	Populate with 'IN'(Insurer)
NM102	Entity Type Qualifier	Populate with '2' (Non-Person)
NM103	Name last or Organization Name	Populate with the 3 character MMIS Carrier Code or Health Plan Code, along with the associated Carrier Name' or Manage Care name. Note: If no TPL found, indicate NO TPL. For example, If Rite Care enrollment/manage care, 3 character Health Plan Code RCN (Neighborhood Health Plan)/RCU (United Health Care) will be used. Otherwise, 3 character TPL carrier code and name

LOOP ID	**2750 REPORTING CATEGORY**	
Segment	**N1 Reporting Category**	
Reference	**Name**	**Rhode Island Requirements**
N101	Entity Identifier Code	Populate with '75' for Participant
N102	Name	Populate with 'MMIS Aid Category'
Segment	**REF Reporting Category Reference**	
Reference	**Names**	**Rhode Island Requirements**
REF01	Reference Identification Qualifier	Populate with 'ZZ' for Mutually Defined
REF02	Reference Identification	Populate with two character 'Aid Category Code' (Report aid category code that is active in MMIS as of report run date.)

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Section 1360:

Transportation Services

December 2013
April 2016

Rhode Island Executive Office of Health and Human Services

Rules and Regulations Section 1360

Transportation Services

TABLE OF CONTENTS

Section Number	*Section Name*	*Page Number*
	1360: Transportation Services for Medicaid & Non-Medicaid Beneficiaries	
1360.01	Covered Services	1
1360.02	Transportation Requests	3
1360.03	Transportation Provider Participation	4
1360.04	Recertification Process	4
1360.05	Claims Billing Guidelines	5
1360.06	Non-Medicaid Elderly Transportation Program	5
1360.07	Non-Medicaid Elderly Transportation Program – Specific Services	6
1360.08	Non-Medicaid Elderly Transportation Program Service Provision Guidelines	7
1360.09	Transportation for Recipients of Temporary Assistance to Needy Families (TANF)	9
1360.10	Complaint Process for Medicaid Beneficiaries, Persons Using the Non-Medicaid Elderly Transportation Program and TANF Recipients	9
1360.11	Severability	10
	Addendum #1	11

Introduction

These rules related to Transportation Services**, Section 1360 of the Medicaid Code of Administrative Rules,** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), as amended, and Title XIX of the Social Security Act.

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

Unless otherwise noted, the provisions contained herein pertain to transportation services for Medicaid beneficiaries, clients of the Non-Medicaid Elderly Transportation Program, and Temporary Assistance to Needy Families (TANF) recipients.

These regulations shall supersede all previous regulations related to transportation services promulgated by EOHHS and filed with the Rhode Island Secretary of State.

1360 Transportation Services for Medicaid Beneficiaries

REV: April 2016

The Executive Office of Health and Humans Services recognizes that Medicaid beneficiaries need available and appropriate transportation in order to access medical care, and assure the provision of such transportation when required to obtain medically necessary services covered by the Medicaid program. Transportation can be provided by any of the following modes, as appropriate to the needs of the individual. Public transit (bus) is the preferred mode of non-emergency medical transportation (NEMT) when both the beneficiary and the provider are within one-half (½) mile of an established bus route.

- Public transit (bus)
- Private Car
- Public Motor Vehicles
- Multi-Passenger Van
- Ambulance
- Wheelchair Van.

1360.01 Covered Services

REV: April 2016

Covered Services - The Medicaid Program covers emergency and non-emergency medical transportation (NEMT). Ground transportation is covered and provided for when the individual has Medicaid and is receiving a Medicaid-covered service from a Medicaid- participating provider.

A) Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation (NEMT) is covered when the recipient has no other means of transportation, no other community resource exists (i.e., family, friends) and transportation by any other means would endanger the individual's health or safety. NEMT may be provided by ambulance if this mode is medically necessary. Physician/clinician documentation or attestation will be required.

To be eligible for NEMT services, Medicaid participants must be unable to find alternative transportation and require transportation services for medical/health visits that are part of a total patient plan of care supervised and ordered by a health care professional.

- If medically justified and communicated during the reservation to the State's transportation broker, an additional person can be permitted to accompany a beneficiary.
- More than one beneficiary may be transported by the same vehicle on the same trip, provided there are adequate seating and safety restraints for all passengers and at no time the health and safety of any of the other passengers are compromised.
- Passengers must not have their trip lengthened by more than 30 minutes due to increasing the number of passengers in the same vehicle.

- Transportation to communities that closely border Rhode Island may be provided for Medicaid-covered services and as pre-authorized by the transportation broker subject to review and approval of the State, as needed. See Addendum "1" or a list of border communities.

B) Emergency Transportation

"Emergency Transportation" means transportation to a medical treatment when required to obtain emergency health care services for unforeseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation is provided by ambulance.

When medical services are obtained at a hospital participating in the Medicaid program, it is the responsibility of the hospital or emergency department staff to provide and pay for appropriate transportation home if needed.

For Medicaid Managed Care beneficiaries, emergency transportation is provided by the Managed Care Organization. Billing for this service is through the Managed Care Organization.

For Medicaid Fee-For-Service beneficiaries, emergency transportation is provided by the Medicaid Fee-For-Service program. Billing for this service is through the Medicaid Fee-For-Service program.

C) Out-of-State Non-Emergency Medical Transportation

With the exception of transportation to communities that closely border Rhode Island, NEMT for out-of-state trips will only be considered for payment when the service is medically necessary and the Medicaid-covered service is either not available in Rhode Island or there are other extenuating medical circumstances.

All out-of-state NEMT, with the exception of NEMT to border communities, requires prior authorization from the State's transportation broker.

D) Nursing Facility Residents

An individual residing in a Nursing Facility whose condition precludes transportation by the facility vehicle to and from a physician's office, medical laboratory, hospitals, etc., may be transported for non-emergency medical services when:

- Patient cannot be transported by any other means through the facility;
- Required medical service cannot be provided within the facility (i.e., portable x-ray services provided in a facility setting);
- Facility has exhausted all other alternative means (including transportation by family or friends) whenever possible.

Emergency medical transportation services can only be provided when a patient is severely ill or injured and transportation by any other means would endanger the individual's health or safety.

1360.02 Transportation Requests
REV: April 2016

All NEMT requests must be scheduled through the State's transportation broker. Some requests may require a physician or clinician's attestation and/or documentation. Information on how to contact the State's transportation broker is available at: www.eohhs.ri.gov.

A) ***Door-to-Door***

"Door-to-door transportation" is defined as transportation of the client from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the transport of the client from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be accessible by means of an ADA-approved (Americans with Disabilities Act) ramp or client-provided assistance.

When necessary, service shall include passenger assistance from the client's door to the vehicle and from the vehicle to the door of the destination and include the return trip. Each client case must be assessed on an individual basis as to need. Beneficiaries must request this service at the time of reservation to the State's transportation broker. Transportation providers are not permitted to enter the client's residence or the provider's office. Beneficiaries who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Beneficiaries must inform the transportation broker when they reserve transportation that an escort will accompany them.

B) ***Passenger Cancellations***

Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation broker at least twenty-four (24) hours prior to the scheduled trip.

C) ***Passenger No-Shows***

Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointment at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance (i.e., will no longer be eligible for "standing order" pick-ups). Clients who frequently (more than three (3) instances per month) do not cancel other scheduled trips (e.g., scheduled physician visits) at least twenty-four (24) hours in advance may also be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

D) ***Physician's/Clinician's Attestation and/or Documentation***

All NEMT transportation requests that require an attestation and/or documentation statement by the recommending physician/clinician must include the specific reason/rationale why NEMT is required based upon a client's functional ability and not only upon diagnosis.

1360.03 Transportation Provider Participation Guidelines
REV: April 2016

Ambulance providers:

- Must have a license issued through the Rhode Island Department of Health (DOH);
- License is renewed annually;

Taxi and Public Motor Vehicles:

- Must have a license issued through the Rhode Island Division of Public Utilities and Carriers (PUC) validating proof of authority to engage granted by the PUC RIGL Title 39 chapter 14 Taxi Cab Statute and Title 39 chapter 14.1 Public Motor Vehicles.
- Providers are required to maintain and ensure drivers have a valid Hackney License (Blue Card).
- A license is renewed annually through the Division of Public Utilities and Carriers.

PUC License Types:
A) Taxi – Public Certificate for Convenience and Necessity

B) Public Motor Vehicles – Certificate of Operating Authority

NEMT

To participate in the NEMT Program, a transportation provider must enter into a signed agreement with the State's transportation broker. Providers must be in compliance with all applicable state and federal statutes and regulations. All providers will be recruited and retained by the State's transportation broker. All required provider documents must be submitted to the State's transportation broker. All providers must meet the requirements set forth by the State's transportation broker.

1360.04 Recertification Process
REV: April 2016

Ambulance providers shall be recertified annually by the Rhode Island Department of Health.

Taxi Public Motor Vehicle Carriers and Providers shall be required to forward a copy of their license or recertification to the State's transportation broker within thirty (30) days of renewal to also avoid interruption of program enrollment.

1360.05 Claims Billing Guidelines
REV: April 2016

The State's transportation broker is responsible for claims and billing for NEMT.

Providers will bill the health plans for emergency transportation provided to Medicaid managed care beneficiaries. Providers will bill the Medicaid Fee-for-Service Program for emergency transportation provided to Medicaid beneficiaries enrolled in the State's Fee-for-Service delivery system.

2) Medicare/Medicaid Crossover Claims

A. **Emergency Transportation**

Medicare is the primary payer for emergency transportation. The Medicaid FFS Program will not make any additional payment on claims where the Medicare payment is equal to or more than the Medicaid allowable amount.

Payment of cross-over claims for Medicaid managed care recipients is handled and directed by the managed care plans.

B. **Non-Emergency Transportation**

Certain forms of non-emergency transportation may be covered by Medicare. This may include basic life support and advanced life support (both of which are provided by ambulance) as well as transportation provided to/from hospitals and dialysis centers. The transportation broker may be responsible for payment of Medicaid-covered NEMT services that were denied by Medicare, subject to prior approval and verification by the broker.

3) Patient Liability

The NEMT payment is considered payment in full. The transportation provider is not permitted to seek further payment from the beneficiary in excess of any payment received from the State's transportation broker.

Transportation providers are not permitted to seek further payment from the participant in excess of any payment received for emergency transportation from either the health plan or the Medicaid FFS Program.

1360.06. Non-Medicaid Elderly Transportation Program
REV: April 2016

The Non-Medicaid Elderly Transportation Program is for individuals age 60 years and older who are not Medicaid eligible and who are not getting transportation from the RIPTA Ride Program or from

the Americans with Disabilities Act (ADA) Program. The Elderly Transportation Program provides transportation to and from medical appointments, adult day care, meal sites, dialysis/cancer treatment and the "Insight Program." The program requires a two dollar ($2.00) co-payment for each trip segment. The $2 co-payment is collected and retained by the transportation driver. Medicaid and "Costs Not Otherwise Matchable" ("CNOM")-eligible co-pay individuals are exempt from this co-pay for transportation in Priorities #1 - #4 in section 1360.07 (below).

The Non-Medicaid Elderly Transportation Program provides safe, quality transportation services to qualified elderly individuals. Emphasis is placed on priority categories of transportation services in relation to existing state funding, vehicle and passenger safety and sensitivity to the needs and concerns of elderly clients. Transportation funds available for this program are specifically allocated for services to be provided for Rhode Island residents sixty (60) years of age and older.

Eligible participants must be legal residents of the State of Rhode Island. As a condition of eligibility for transportation services, participants must provide the information noted below to the transportation broker. This may include, but is not limited to:

1. Date of birth;
2. Proof of residency (e.g., valid Rhode Island driver's license and/or Rhode Island state identification card issued by the Rhode Island Division of Motor Vehicles; voter identification card; current utility bill for a residence within Rhode Island in the name of the individual requesting transportation services);
3. Social Security number;
4. Medical documentation as requested by the State's transportation broker.

1360.07 Non-Medicaid Elderly Transportation Program – Specific Services
REV: April 2016

The following transportation services may be provided to Rhode Island elders by the State's transportation broker based on the following prioritization. Service provision is contingent upon available state funding.

Special Medical Care (Priority 1)
Special medical transportation includes transportation for the purpose of kidney dialysis or cancer treatments. Names of clients to be transported are to be provided to the State's transportation broker by the medical treatment facility, family, friends, or the client themselves. The State reserves the right to limit special medical transportation based on funding constraints or other programmatic requirements.

Adult Day Care (Priority 2)
This category includes transport to and from Adult Day Care Centers that are licensed by the Department of Health (DOH). Residences of clients shall be verified by the Adult Day Care Center

and provided to the State's transportation broker. The State reserves the right to limit transportation to Adult Day Care centers based on funding constraints or other programmatic requirements.

General Medical Care (Priority 3)
This category includes transportation for any medical/health services that are part of a total patient plan of care supervised by a health care professional. Trips eligible under this service category include visits to physicians' offices and dental offices as well as all trips for tests and/or treatments ordered by a health care professional as part of a treatment plan. The State reserves the right to limit General Medical transportation based on funding constraints or other programmatic requirements.

INSIGHT (Priority 4)
This category includes transport to and from INSIGHT, at their INSIGHT service location(s). Riders must be sixty-five (65) years of age or over, have a sight impaired condition and/or presently registered with the INSIGHT agency.

Transportation shall be at the discretion of the State and available during the same days and hours as General Medical trips. Trip requests must be forwarded to the State's transportation broker at least forty-eight (48) hours in advance. The State reserves the right to limit transportation to INSIGHT based on funding constraints or other programmatic requirements.

Senior Nutrition Transportation (Priority 5)
This category includes transport to and from congregate meal sites for the elderly. The Senior Nutrition Project shall be responsible for securing names and addresses of individuals to be transported. This information shall be forwarded to the State's transportation broker for scheduling. The Nutrition Site shall verify residence of all individuals in the geographic area. The State reserves the right to limit transportation to specific meal sites based on funding constraints or other programmatic requirements.

1360.08 Non-Medicaid Elderly Transportation Program Service Provision Guidelines

REV: April 2016

Limitation on Transportation
The State reserves the right to limit or restrict the availability of transportation due to funding constraints, service availability, weather, etc. (This provision applies to clients of the Non-Medicaid Elderly Transportation Program only).

Door-to-Door
"Door-to-door transportation" is defined as transportation of the client from the outside door of his/her residence to the outside door of his/her destination, including the return trip. "Door-to-door" is further defined herein to mean the transport of the client from the ground level door of his/her residence to the ground level door of his/her destination, including the return trip. The dwelling should be accessible by means of an ADA-approved (Americans with Disabilities Act) ramp or client-provided assistance.

When necessary, service shall include passenger assistance from the client's exterior door to the vehicle and from the vehicle to the exterior door of the destination and include the return trip. Each case must be assessed on an individual basis as to need. Participants must request this service at the time of reservation to the State's transportation broker. Transportation providers are not permitted to enter the client's residence or the provider's office. Participants who will require additional assistance in leaving their destination or upon arrival at their medical appointment may bring an escort with them. Participants must inform the transportation broker when they reserve transportation that an escort will accompany them.

Transport to Nearest Sites

Transportation to meal sites, kidney dialysis, and cancer treatments shall be to the facility closest to the client's home, whenever possible. If not possible, the participant shall receive approval from his/her physician or primary care provider to receive such services at another site based on medical necessity.

Transportation to adult day care facilities shall be to the facility closest to the client's home unless transportation to another center is more appropriate. This is also subject to the availability of transportation services to that center. General medical trips shall be to the nearest health care professional whenever possible unless the participant has received approval from his/her physician or primary care provider to receive such services at another site based on medical necessity.

Days and Hours of Service

Service days shall typically include Monday-Friday. Trips may also be scheduled on weekends and holidays when medically necessary. Trips for Senior Nutrition Transportation (Priority 5) must occur between 10:00 a.m. – 2:00 p.m.

Passenger Cancellations

Passengers must make every effort to keep their scheduled trip appointments. If unable to keep an appointment, notification must be provided to the State's transportation broker at least twenty-four (24) hours prior to the scheduled trip.

Passenger No-Shows

Passengers who frequently (more than three (3) instances per month) do not cancel their regularly scheduled trip appointments at least twenty-four (24) hours in advance may be required to schedule each trip separately at least two (2) days in advance (i.e., will no longer be eligible for "standing order" pick-ups). Passengers who frequently (more than three (3) instances per month) do not cancel other scheduled trips (e.g., separate physician visits) at least twenty-four (24) hours in advance will also be required to confirm scheduled trips the morning of or twenty-four (24) hours in advance.

After a sixty (60) day period, passengers may request reinstatement of eligibility for standing order and scheduled ride pick-ups without being required to confirm such trips in advance. Requests will be subject to EOHHS approval.

Passengers with a frequent pattern of no-shows will receive written notice from the State's transportation broker that they will be subject to a change in their transportation benefit. (See section 1360.10 herein, "Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF recipients").

1360.09. Transportation for Recipients of Temporary Assistance to Needy Families (TANF)
EFF: April 2016

Recipients of the State's Temporary Assistance to Needy Families (TANF) Program are eligible to receive a monthly bus pass. To obtain a monthly bus pass, TANF recipients must call the State's transportation broker to request a pass.

Bus passes will be mailed to the recipient following the request.

1360.10 Complaint Process for Medicaid Beneficiaries and Persons Using the Non-Medicaid Elderly Transportation Program and TANF Recipients
REV: April 2016

Individuals may file a complaint as follows:

- Passengers or their family members may submit a formal written or verbal complaint to the State's transportation broker at: 1-855-330-9131 or 1-866-288-3133 (for hearing impaired).
- The State's transportation broker will attempt to resolve the complaint with the individual or his/her family.
- In the event transportation benefits are terminated or substantially altered, after due notice, and the complainant wishes to pursue his/her concerns further, the written complaint shall be forwarded to the State for a fair hearing. State fair hearings shall be conducted in accordance with the provisions of the Medicaid Code of Administrative Rules, Section #0110 "Complaints and Hearings" promulgated by EOHHS and available on the Secretary of State's website: www.sos.ri.gov/rules.
- In the event transportation benefits are terminated or substantially altered due to a lack of Program funding, formal appeal rights to a Medicaid fair hearing shall not be available.
- Individuals who fail to show up at their scheduled pick up time will receive written notice from the transportation broker that they will be subject to a change in their transportation benefit if they fail to show up for four (4) or more rides. Individuals will receive a warning letter for each of three (3) failures to show up, followed by a fourth letter notifying them they are being moved to mass transit or gas mileage payment because they failed to show up for a scheduled ride four (4) or more times. Individuals will receive written notice on how to appeal this determination in accordance with the provisions of this section.

1360.11 Severability

If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

April 21, 2016
1360transfinalfinalapril2016

Addendum 1
Border Communities

Border Communities include cities and town that border Rhode Island and are considered for the purpose of the Rhode Island Medical Assistance Program, in-state providers. Out-of-state service restrictions and prior authorization requirements are not imposed on providers in the following communities:

Connecticut	***Massachusetts***
Danielson	Attleboro
Groton	Bellingham
Moosup	Blackstone
Mystic	Dartmouth
New London	Fall River
North Stonington	Foxboro
Pawcatcuk	Milford
Putnam	New Bedford
Stonington	North Attleboro
Thompson	North Dartmouth
Waterford	Rehoboth
	Seekonk
	Somerset
	South Attleboro
	Swansea
	Taunton
	Uxbridge
	Webster
	Westport
	Whitinsville